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ABSTRACT

This volume presents the proceedings of a seminar concerned with community care for the chronically mentally ill. After an introductory overview by Ira Iscoe, the first section consists of the following major addresses, presentations, and commissioned papers: (1) "The Community as the Primary Locus of Care for Persons with Serious Long-Term Mental Illness" (Leonard Stein); (2) "Asylum and Community: Friend Not Foe" (Steven Schnee); (3) "State Agency Collaboration on Mental Health Issues from a Political Perspective" (Michael Churgin); (4) "The Future of Community Care for Persons with Chronic Mental Illness" (Dennis Jones); and (5) "Community Care for the Chronically Mentally Ill: Summary Comments" (David Mechanic); (6) "Current Issues in Mental Health Law" (Arlene Kanter); (7) "Model Programs for Persons with Chronic Mental Illness" (Martin Cohen); (8) "Estimates of Need for Mental Health Services in Texas Counties" (Charles Holzer et al.); (9) "State Hospital Reform in Texas: A History of the R. A. J. Class Action Lawsuit" (David Pharis); (10) "Children's and Adolescents' Mental Health Needs in Texas" (Regenia Hicks); (11) "Families of the Mentally Ill in Texas" (Carmen Johnson and Dale Johnson); and (12) "Financial Costs of Caring for the Chronically Mentally Ill in Texas (David Warner). Also included is a series of workshop summaries on technological and innovative advancements, implementation, collaboration, and training. Appended are the scope statement of the Commission on Community Care of the Mentally Ill and lists of the program planning committee, workshops, and participants. (TE)

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# Proceedings of the Sixth Robert Lee Sutherland Seminar in Mental Health

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# COMMUNITY CARE OF THE CHRONICALLY MENTALLY ILL

Proceedings of the Sixth Robert Lee Sutherland Seminar in Mental Health

*Editors* Charles M. Bonjean
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# Overview: The Sixth Sutherland Seminar in Mental Health

Ira Iscoe, *The University of Texas at Austin*

How best to care for and treat persons suffering from chronic mental illness has been a problem to Western society for hundreds of years. Depending on a complex combination of social, financial, and political factors, different approaches have been tried and different agencies have been delegated legal responsibility. The introduction of antipsychotic drugs in the mid 1950s greatly alleviated some of the more serious signs of chronic mental illness, such as delusions, hallucinations, and stereotypic behavior. The recognition of the negative effects inherent in overcrowded mental hospitals led to the Community Mental Health Centers Act of 1965, frequently referred to as the "Third Mental Health Revolution." Through its provisions and Social Security legislation, hundreds of thousands of patients were released from state and county mental hospitals. Some were absorbed into facilities for older persons while others were discharged with the expectation that new community mental health centers would provide for their care and treatment.

It soon became apparent that the existing and newly established community-based facilities were not adequate resources for the severely emotionally disturbed (SED). Many ex-patients took refuge in single-room occupancies (SROs), while a majority lived with families, relatives, and friends. The staffs of the newly formed community mental health centers lacked both the resources and skills to be of continued assistance to the severely mentally ill and their families. Many discharged patients suffered a deterioration in quality of life and treatment, frequently joining the ranks of the homeless and also swelling the population of county jails and prisons. Conditions have worsened to the extent that finding ways in which chronically mentally ill persons can function in community settings has become a high priority, at both the state and national levels. For a great majority of the chronically mentally ill, community settings offer a potential for a richer life as well as the advantage of lower cost than institutional approaches.

Clearly, problems of enormous complexity confront those who plan services for the chronically mentally ill. Should any one discipline be responsible for this population? If so, to what extent and under what conditions? What changes are needed in order to develop community support systems for the skillful and humane treatment of the severely emotionally disturbed? What new thinking is necessary in our concepts of

sanctuary and asylum? What proportion of the chronically mentally ill can be accommodated within a community context? What innovative types of collaboration between the private and public sectors are called for in order to improve services? How can the present mental health delivery systems be more helpful to the chronically mentally ill and their families? What types of public education are needed for a better understanding of the nature of severe emotional disturbances? How can stigma and mistaken perceptions about the mentally ill be counteracted? What should be the appropriate involvement of patients, families, relatives, and communities in treatment? The above are only a number of the vexing and complicated questions to which no clear answers can be given at present. Continued research is necessary if an equitable way of coping with the problems is to emerge. The issue remains one of the most challenging public health problems facing our nation. Its very persistence throughout the years is an indication of its difficulty.

## Background

The present volume is a product of the Sixth Robert Lee Sutherland Seminar, held September 30–October 1, 1988, in Austin, Texas. The decision to title the seminar "Community Care of the Chronically Mentally Ill" was made in recognition of the salience of the problem in Texas and in furthering the Hogg Foundation's abiding interest in this area. One of the lifetime concerns of the late Robert Lee Sutherland was the humane treatment and care of the severely mentally ill. The Seminar's Planning Committee had as one of its goals the emergence of a document that should be of material assistance to individuals, groups, and agencies concerned with the chronically mentally ill.

In planning for its 50th anniversary in 1990, the Hogg Foundation Executive Staff, in consultation with its National Advisory Committee and Faculty Advisers, in spring 1987 set up three statewide commissions directly related to the mental health of the people of Texas. Commission I was to deal with the community care of the severely mentally ill. The subject for Commission II would be the mental health of children and their families, while Commission III would focus on mental health problems of adolescents and young adults.

Members of Commission I were appointed during the summer of 1987. Activities of the Commission would run through the year 1990, with a final report due sometime in 1990. It was agreed that this Commission would also play a prominent part in the Sutherland Seminar scheduled for the fall of 1988. Commission I held its first meeting in September 1987, worked out its scope statement (Appendix A), and approached its mandate with enthusiasm and cooperation. Materials dealing with relevant aspects of the

Commission's work were circulated on a continuing basis and guest speakers were invited to Commission meetings. Through such contacts, a common background of knowledge for the entire Commission was established and continues today as the Commission prepares to write its final report—a fair proportion of which will be based upon proceedings and recommendations of the Sixth Sutherland Seminar.

In order to facilitate the work of the Commission, the group was divided into four committees: (1) Technological Innovations in Training and Treatment, (2) Implementation of Commission Recommendations, (3) Levels of Training, and (4) Collaboration at the Local and State Agency Levels. Selected Commission members served on the Planning Committee for the Seminar. The four Commission committees were redesignated as Task Forces for the Seminar. Then the Seminar's 150 invited participants were given the choice of task forces on which they wanted to serve.

Much of the success of any conference depends on the quality of preconference planning and circulated materials. The Seminar's Planning Committee chose carefully from an enormous amount of published materials and also decided to commission a small number of papers which would be of particular interest to the Planning Committee as well as to participants. A careful reading of the documents sent to the participants supports the contention that they represent an outstanding "mini-course" in the area of the community treatment of the chronically mentally ill. The final program stands as an example of careful deliberation and excellent cooperation between the Commission and the Planning Committee.

The present volume makes a distinct contribution in planning for the effective care and treatment of the chronically mentally ill in the state of Texas. It recognizes not only the geographic but the ethnic diversity of the state. It also recognizes that only through the genuine collaboration of state and private agencies will there be significant advances in this most complex problem. More than ever a concerted, intelligent, research-based approach is needed to deal with the chronically mentally ill population. To use the word "solution" would be naive. However, more effective coping with the myriad of problems presented by the chronically mentally ill is a responsibility that cannot be avoided. The volume can well serve as a framework for planning effective and relatively economical ways of meeting the mental health needs of the chronically mentally ill and their families.

## Major addresses and presentations

Leonard I. Stein, "The Community as the Primary Locus of Care for Persons with Serious Long-Term Mental Illness"

Steven B. Schnee, "Asylum and Community: Friend Not Foe"

Ray Farabee, "State Agency Collaboration on Mental Health Issues from a Political Perspective"

Michael J. Churgin, "Intrafamily Conflict and the Delivery of Mental Health Services: Whose Rights Prevail?"

Dennis R. Jones, "The Future of Community Care for Persons with Chronic Mental Illness"

David Mechanic, "Community Care of the Chronically Mentally Ill: Summary Comments"

# The Community as the Primary Locus of Care for Persons with Serious Long-Term Mental Illness*

Leonard I. Stein, *University of Wisconsin Medical School; Director, Mental Health Services Development Program of the Robert Wood Johnson Foundation*

This paper describes the conceptual framework for the treatment of persons suffering from serious long-term mental illness (SLTMI), discusses both the organizational principles required to develop an integrated service system and the clinical principles required to serve the individual in need of services, and finally describes a system of care based on those principles. Before going on to those three areas, I would like to clarify the debate about deinstitutionalization.

We have read about the homeless mentally ill, the mentally ill filtering into our correctional institutions, the mentally ill rotating in and out of our hospitals, and the mentally ill being inappropriately warehoused in large nursing homes, which are worse than the state hospitals they came from. We are told that these are the consequences of deinstitutionalization and thus deinstitutionalization has failed. To understand what went wrong, we must remember that deinstitutionalization was conceived as a two-step process: (1) reduction in the use of large public mental hospitals and (2) the coincident development of a comprehensive system of community-based care for those patients who were formally "served" by those hospitals. We know the first step was enormously successful. We have reduced public mental hospital populations from more than 550,000 in 1955 to less than 120,000 today. Unfortunately, in most parts of the nation, the second step has not yet been adequately accomplished.

This failure to develop adequate community-based systems of mental health care for those suffering from SLTMI has led to the negative consequences described above, and thus we have replaced one poor system of care, the "warehousing" of patients in large state institutions, with another system that is equally inadequate and inhumane—neglect, as reflected in the homeless mentally ill and the incarceration of mentally ill in jails; transinstitutionalization as reflected through the warehousing of the

*Portions of this paper have been previously published in the following *New Directions for Mental Health Services* articles: "The Dollar Follows the Patient" (no. 18, June 1983), "A Program for Difficult-to-Treat Patients" (no. 26, June 1985), and "Wisconsin's System for Mental Health Financing" (no. 43, forthcoming). Copyrighted by Jossey-Bass Inc. Reprinted with permission.

mentally ill in large nursing homes; and the "revolving door" syndrome which allows patients in our communities to deteriorate, necessitating hospital care for stabilization, to be followed again by discharge back to inadequate care in the community, only to deteriorate again and return to the hospital again and again.

Fortunately, in the past 20 years we have accumulated the knowledge and have developed the techniques to provide patients suitable care and a fuller life in the community, thus drastically reducing the need to use the hospital. *Thus, deinstitutionalization has not failed; rather, there has been a failure to complete the deinstitutionalization process through the development of comprehensive systems of community-based care for persons with SLTMI.* The research strongly supports this assertion. In every instance where a comprehensive system of community care for SLTMI has been established and evaluated, it has been found to be successful (Kiesler, 1982; Stein & Test, 1985).

## The Clinical Problem

To understand the kind of treatment the SLTMI person requires, it is important to understand the illness. These persons suffer from a chronic illness whose onset is in late adolescence or early adulthood and which is often lifelong in duration. To date we neither know how to cure nor prevent the illness. However, as noted above, over the past 20 years we have learned a great deal about how to improve its management. It is an illness characterized by exacerbations and remissions—i.e., there are periods when it worsens and periods when it is more quiescent. During a flare-up, the psychotic phase of the illness, the patient suffers an impairment in his ability to test reality. The patient may hear voices, believe he is being persecuted, and behave in bizarre ways. In most cases we can effectively treat the psychotic phase through the use of medications, and at times use of the hospital is necessary. During the quiescent period the patient is generally in good touch with reality but suffers from other impairments which interfere with his ability to organize and maintain the resources required to make an *unassisted* stable adjustment to community life. These impairments are the following: sensitivity to stress, difficulty with interpersonal relationships, a deficit in coping skills, and difficulty in transferring learning from one site to another. The overall therapeutic strategy must address both the psychotic and quiescent phases and requires a double-pronged approach. The first, as noted above, is primarily medical and is directed toward interrupting the psychotic phase as rapidly as possible. The second has a more rehabilitative focus and is directed toward the impairments of the quiescent phase where efforts are made to increase

functional capacity and psychological stability through skill training, psychological and environmental supports, and maintenance medication when indicated. The efforts of both prongs interact to increase stability and functional capacity to a greater degree than either one could do alone. This therapeutic strategy is no different than that used with other chronic illnesses such as arthritis or diabetes, which we as yet do not know how to prevent or cure but have learned quite well how to manage.

The major clinical problem presented by persons suffering from SLTMI is helping them organize and maintain whatever is necessary to establish a stable adjustment to community life. The needs are quite obvious; in essence they need exactly what the rest of us do: a place to live; an opportunity to socialize; useful vocational or avocational activities that anchor the day and give meaning to life. They also need finances, medical services, mental health services, and crisis resolution services. Their only need that the rest of us do not specifically require is public support for the community in which they live. Any treatment organization that works with this population must understand that supporting the community is just as important as providing support to patients.

As noted above, the SLTMI person has difficulty in organizing and maintaining the necessities required to make a stable adjustment to community life. This problem is a consequence of long-term impairments, sensitivity to stress, difficulty with interpersonal relationships, deficit in coping skills, and an impaired ability to generalize learning. These impairments are ongoing, do not respond to medication, and must be addressed on an ongoing basis. Research has clearly shown that hospital treatment does little to influence these impairments (Anthony, Buell, Sharratt, & Althoff, 1972) and that community treatment does have a significant impact on helping patients maintain a stable adjustment to community life (Stein & Test, 1980). In summary, effective treatment of SLTMI must have a comprehensive and integrated system of community-based services as the *primary locus* of care.

## The Organizational Problem

Unfortunately, the large majority of our communities cannot appropriately address the clinical problem because they do not have comprehensive and integrated services. A brief historical overview of the development of mental health services in the United States will help explain the roots of this organizational problem.

In the middle 1800s, Dorothea Dix, concerned about the neglect of the mentally ill, lobbied states to take on the responsibility for their care. States responded by building hospitals to house and treat the mentally ill. Over the past two decades a variety of community services developed which, for the most part, operated independently of one another and in isolation from

hospitals. In virtually every state it is still the case that hospital programs and a mix of community programs are operated in an uncoordinated and noncollaborative fashion, often competing with one another for funds and, at times, even competing for patients. Together these services comprise a "nonsystem" of mental health care, where a few patients get more than they need, many patients get less than they need, and some get nothing at all. Patients commonly get lost in this nonsystem, with no one feeling obligated to seek them out. When patients refuse to follow a program's rules, they typically are terminated from treatment by staff who believe they have no other choice. Patients are moved from the community into the hospital, and from the hospital back into the community, such that the hospital, the community, the patient, and the family all feel mistreated. This nonsystem is failing the patient and undermining the potential effectiveness of the professionals working in it.

## Organizational Principles

The principles organizing a system of care are as important to the final goal of providing effective treatment as are the clinical principles that guide the front-line clinician. Below are five organizational principles that greatly facilitate developing a system of care:

I. For every service area (conceptually similar to catchment area) there must be one central authority that is responsible for planning the service system. In developing its plan, the central authority should solicit participation from a broad range of professionals—from the mental health, social service, rehabilitation, housing, and government financing areas—and from consumers, families of consumers, and other interested citizens.

II. This central authority must have control of all the public dollars and use that money to fund all needed services. This control over funding must include funding of state hospital services. A variety of models exists that the central authority could use to fund needed services. For example, if the central authority were county government, the county could provide the services by having a county mental health clinic, a county-run psychosocial club, and so on. Another possibility would be for the county to contract for all services rather than provide them itself; or it could do a combination of both.

III. The central authority must be responsible for the care of all patients in that central authority's area. In order to carry out the responsibility, every patient is assigned either to a case manager or to a core service team that, among other things, fulfills case management responsibilities. The case manager, whether this is an individual clinician or an entire core service team, assumes responsibility for all aspects of the care a patient may require in order to live satisfactorily in the community. We have found

that while the more stable patients with SLTMI can be well served by an individual clinician functioning as the case manager, more difficult patients with more pressing needs and more frequent crises require an entire team to share case management responsibilities. These responsibilities include either providing all of the needed services or arranging for missing services to be provided by another agency. In all cases, the case manager remains responsible for making sure that needed services are provided. This broadly based care, as noted above, includes psychiatric treatment, rehabilitation, housing, finances, and so on.

IV. Since SLTMI is an illness of long duration, the system must not have arbitrary time limits for segments of its treatment. Said another way, the length of time a patient receives services must depend on that particular patient's needs and not on an arbitrary time span. This has not been the practice for most services in the United States, where services have been provided on a time-limited basis with the expectation that the patient will make a transition through the services and at some point will no longer need any service at all. Of course, a system must do all it can to help patients make the transition from more intensive to less intensive services if it is going to help patients improve and, at the same time, use its resources as economically as possible; however, to set arbitrary time limits is clinically inappropriate.

V. The central authority must ensure that services are balanced and thus must not allow itself to become aligned with one or another of the professions that are competing with each other for status and funds. The central authority must recognize that rehabilitation, psychiatry, self-help groups, and others can complement one another and are all needed to contribute to the service package. The central authority must face the difficult task of making funding decisions based on clinical needs and resist making them primarily in response to political pressures.

## The Principles of Treatment

The following section describes the principles we have found effective in working with the patient and working with the community.

### Working with the Patient

*An Assertive Approach.* Frequently patients do not seem to be motivated to stay involved with the treatment program. In fact, what is most frustrating about their willingness to be involved is that it is highly variable. There are times when a patient will seek help; at other times the same patient does not want to have anything to do with your program. To accept being fired by the patient with a shrug of the shoulders and a comment that "unmotivated people can't be helped" is, in essence,

evidence of poor clinical judgment. Lack of motivation or variability in motivation is part of the basic illness. If this lack is passively accepted, there is a high probability that in a relatively short period of time the person will again regress into psychosis, be hospitalized, and be referred at discharge to start all over again.

Programs must be assertive in keeping patients involved. If someone does not show up for an appointment or for his job (a careful monitoring system must be set up to keep staff apprised of this), staff should go out and find the person. They may have to go to his home or drive to areas they know he frequents. When they find him, they should try to learn what he perceives his problem to be and then try to explain how they may be helpful to him. The patient may say no the first few times this is tried, but in our experience, with a persistent effort, patients will eventually come back into the program. This approach has markedly reduced dropouts from our programs in Dane County, Wisconsin.

*Individually Tailored Programs.* Patients have a wide variety of needs. To help provide these needs in the most efficient way possible, individualized programming must be developed. Patients should be carefully assessed for a broad range of needs, from housing and finances to socialization and medication. A program is then designed to ensure the patient is provided what he needs in order to make a stable adjustment to community life. The patient is carefully monitored, and the program changed to meet changing needs.

*In Vivo Services.* As noted earlier, many of our patients do not transfer learning from one place to another very well. For example, in our Dane County programs we used to teach patients how to cook in the model kitchen in the hospital and to shop in the supermarket near the hospital. After discharge, we visited patients and found to our surprise that they were not shopping in their local supermarkets or using the stoves in their kitchens. We tried to find out why and learned that when they went to their local supermarket they found that the aisles were labeled A, B, C, and D instead of 1, 2, 3, and 4. In addition, they said, they tried finding what they wanted, but the products were not in the aisles where they expected to find them; they next began to feel that people were staring at them. They left the supermarket as fast as they could and did not go back.

These experiences taught us that patients' skills must be carefully assessed to determine which ones might be generalized; such skills can then be taught in a group setting. Patients unable to transfer their learning need staff going to their homes and neighborhoods to teach them how to shop in *their* supermarkets, to cook in *their* kitchens, to use the specific bus routes they need to get from home to their supported work placement, and so on.

*Capitalizing on Patients' Strengths.* Paying attention to patients' strengths instead of spending a lot of time on their pathology is of key importance. For example, a patient, Mary, got a job as a maid in a hotel. One of our workers spent two or three days working side by side with her helping her to learn how to do her various tasks. Then he weaned himself away from her, and things went well for one day. On the second day we received a phone call. Mary said, "I have got to get back to the hospital." We said, "What's the matter, Mary?" She said, "The TV set in every room I walk into is controlling my mind and telling me what to do." That particular delusion is a common one for Mary to develop during her psychotic phase. Rather than explore the meaning of the delusions, we asked her, "What happened today?" She replied that nothing had happened. We told her that she was obviously upset about something, and asked again what had happened. She finally told us that the supervisor said she doesn't know how to make the beds correctly. We told her that we would be right over. One of our mental health aides checked with the supervisor, and, sure enough, Mary wasn't making the corners on the bed the way the supervisor wanted them made. The aide spent another day with Mary helping her learn how to make better corners on the bed. After she learned that and was complimented by the supervisor, the voices from the television sets stopped telling her what to do. Thus, it is useful to focus on the strengths of patients rather than focusing only on pathology.

*Titered Support.* In their training, mental health professionals are almost made phobic about giving patients psychological support. Although overdependency can be a problem, persons with SLTMI are going to be dependent on mental health professionals, to a greater or lesser degree, for the rest of their lives. The strategy is to increase the independence to the greatest degree possible without going beyond what the patient can tolerate. To do this requires good clinical judgment. The amount of support given is highly variable and is dependent on the patient's current clinical need. For example, there will be some days we will give a person a great deal more support than two days earlier or two weeks later. In summary, the patient needs support, and good clinical judgment must be utilized in order to titer the support so that patients get what they need but not more. A good "rule of thumb" regarding the giving of support to persons with SLTMI is "When in doubt, give the support."

*Relating to Patients as Responsible Citizens.* This attitude is extremely important for staff to adopt in order to work effectively with patients as well as with the community. The staff must believe that the people they are working with are citizens of the community; that they are living in the community because they have a *right* to and not because the community is

*allowing* them to be there; that patients are indeed free agents able to make decisions and be responsible for their actions. These attitudes influence clinical behaviors. Take, for example, the medication issue. Patients are frequently ambivalent about taking medications. We find we get better compliance if we relate to patients as responsible and make them partners in the medication decisions. We are willing to negotiate about dosage, we are willing to set a range within which patients can control their own dosages dependent on how they perceive their needs. This approach makes them a part of the treatment process and treats them as responsible persons.

Another important clinical reason to treat patients as responsible is that many of them have learned that illness is an excuse for their behavior. Patients must be disabused of this notion. They can be told that indeed they are ill, otherwise they would not be in need of medication, but that their illness is not an excuse for their behavior. They can be told that everything possible will be done to see to it that their positive behaviors are rewarded, but also that their negative behaviors will have the same consequences that would result for anyone else behaving that way. For example, we had one patient who would want to be rehospitalized whenever he became even mildly stressed or anxious. His way of accomplishing that would be to go into a supermarket, take some soda and candy, and walk through the line without paying for it. If he was not apprehended, he would simply walk back in and take more until someone called the police. He would then get into the police car and half a block down the road would say to the policeman, "Oh, by the way, I'm a patient at Mendota State Hospital." At this point, the policeman would sigh with relief, turn the car sharply and give him a free taxi ride to the hospital. The policeman not only thought he was doing a good thing; he also avoided having to take him downtown, book him, write a detailed report, show up in court, and so on. To avoid the problem of the police taxiing the patient to the hospital, we had to work very closely not only with the police but with the district attorney and the judges to see to it that this kind of minor crime was handled as it would be for any other citizen. The next time this patient shoplifted at a supermarket he indeed went before a judge; the judge gave him the stern lecture he gives to all first offenders for a crime of this nature. The judge told him that "if you ever do this again you will spend three days in the county jail or have a $50 fine." For most patients that was sufficient to stop the behavior. However, this patient shoplifted again, and since he didn't have $50 he proceeded to spend three days in the county jail. Our staff spent a good deal of that three days at the jail as well, working not only with the patient but with the jailers to make sure everyone got through the three days all right. We found that with this approach the above-noted maladaptive coping with the stress dropped precipitously. We do not advocate using this approach for people who break the law who are in the midst of a psychotic episode.

Good clinical judgment must be exercised to determine when this approach should be used (Stein & Diamond, 1985b). It should not be difficult to determine when a patient is consciously breaking the law as a maladaptive coping strategy and when he or she is doing things because of being out of touch with reality.

*Crisis Resolution Available 24 Hours a Day.* This is a necessary part of a program when working with this group of patients. These patients don't limit their crises to nine to five, Monday through Friday. Hospital admissions, reflecting that fact, generally are overrepresented after five at night, on weekends, and on the holidays—periods of time when the normal support system is unavailable. Twenty-four hours per day availability of an appropriate crisis response ensures that a support system is always available to the patient. An important spinoff benefit of our crisis team is that it has markedly reduced hospitalization and thus has saved our system hundreds of thousands of dollars a year in inpatient costs. Those saved dollars are largely responsible for making it possible to operate our other community-based programs (Stein & Ganser, 1983).

## Working with the Community

Providing support to the community members who are in contact with our patients such as family members, landlords, storekeepers, agencies, and so on is just as important as working with the patient himself. These community members' attitudes about and modes of relating to patients are significant factors in influencing how well our patients do. The following are the principles we use in working with the community.

*An Assertive Approach.* Just as appropriate assertiveness is crucial in working with patients, it is also crucial in working with the community. For example, if one lets things slide with a landlord or an agency to the point where a decision has been made to evict or terminate the patient, it is then usually too late to repair the problem. The patient is extruded from that situation, and the results of that extrusion are not only stressful to the patient but create a great deal of work for your staff. The solution is to monitor closely the relationship that your patient is having with the community with which he or she is in contact and to intervene early when difficulty presents itself.

*Utilization of a Wide Variety of Community Resources.* There are many public agencies that advertise themselves as providing services to the citizens of the community, but never contemplated that they would be asked to provide those services to psychiatric patients. We recommend taking advantage of those agencies and getting them to provide services to

psychiatric patients. Let me give you two examples. One is the Visiting Nurse Service (VNS). A number of years ago the VNS in Dane County had virtually no psychiatric patients in its caseload. At the present time quite a number of their caseload are psychiatric patients. They give many of our Prolixin injections; they visit and provide support to patients in their homes; they serve an important monitoring function (if you really want to know how a patient is doing, visit his home and see how he is functioning there). Thus, the VNS has become a tremendous asset to us.

When we first approached them they were not jubilant about doing what they are now quite happy to do. They said, "We really don't know much about treating psychiatric patients and will probably do them more harm than good. Our staff doesn't have proper training." We said in return that we understood their anxiety and would have one of our staff members accompany one of their staff members until their staff felt comfortable without our presence. They agreed, and we gave them the support and on-the-job training they needed. Now none of our staff members has to be with the Visiting Nurse Service. An added bonus is that the VNS has become a strong advocate for community treatment. We have had the same experience with other agencies that have not had prior experience with this population. Once they get to know the patients and work with them over a period of time, they come to know patients as people; prior prejudices or myths that they might have had evaporate.

Let me give you one more example because it was one with which we had a difficult time. There is an agency that advertises itself as teaching homemaking skills to the citizens of the community. We went to that agency and told them that we had a group of citizens who could use their help, and we further told them that these citizens had a psychiatric disability. They told us what we expected to hear; their staff "had no experience with psychiatric patients and would probably do them more harm than good." We tried our standard approach by telling them we understood how they felt but would offer as much support as they needed, and we offered to have our staff members accompany theirs until they were comfortable enough to operate without them. They still refused. We then called their attention to the fact that they were a United Way agency and that the United Way had a rule that their agencies could not discriminate on the basis of disability. They advised us that they would be willing to take their chances with that, since not a very large part of their budget came from United Way. We then told them that the City of Madison had an ordinance which prohibited discrimination and that, if they continued to refuse, we would take them to court. It was at this point that they reluctantly agreed to work with our patients. The ending of the story is another happy one in that, given sufficient support, their staff indeed became comfortable with our patients. with a similar result to the one noted for VNS.

This second example makes the point that, if one is truly interested in getting the community to work with and accept these patients, there are times when one has to be willing to go the full route. It is difficult for any staff to go the full route unless they truly believe that these patients have a right to these services, that they have a right to live in the community, and that the staff does not have to feel humbly grateful to the rest of the community for allowing patients to be there. It is absolutely critical that your staff deeply believe that your patients are full citizens of the community and have the rights of all citizens. You must feel this to the depth of your soul so that you are imbued with the appropriate values that will help motivate you to instill those values both in your patients and in the community. I would like to emphasize that agency cooperation is not obtained by simply demanding it. It is necessary that your staff provide sufficient support in order to gain agency cooperation.

*Providing Support and Education to Community Members*. In addition to agencies, it is important to provide support and education to families, to landlords and shopkeepers, and to whomever your patient comes into significant contact with. Rather than attempting to mount a mass education program, we decided to educate and support community members every time there was a problem between a patient and a community member. For example, if we learned that one of our patients was having trouble with a shopkeeper, we would get together with the shopkeeper and do several things. First, we would teach the shopkeeper to relate to our patient in a very straightforward and unambiguous manner. After teaching him how to relate to our patients, we would use the event as an opportunity to teach about chronic mental illness. We would give the shopkeeper a realistic appraisal of that particular patient's dangerousness as well as the fact that chronic mentally ill people are no more dangerous than a random selection of the general population sharing the same age, sex, and socioeconomic status. We would then help him understand why a community-based approach made more sense than institutional care, and we would emphasize that, although we might not approve of some of their behaviors, as good citizens we must be willing to tolerate nonlawbreaking deviant behaviors. Finally, we would leave the shopkeeper our card with our name and phone number on it and urge him to call us any time, 24 hours a day, seven days a week, if he experienced any problems or had any questions relating to our patients. We found that providing this kind of education and support has led to greater community acceptance of our patients.

*Retaining Responsibility for Patient Care*. Coordination and continuity of the many services required by this patient population is necessary to a well-functioning community support system. In the past, we in mental

health relied on referral and interagency communication as the means to attain coordinated and continuous services. This did not work; services frequently were poorly coordinated and incomplete, and patients were lost to treatment. Although referral and interagency communication are necessary, they are not sufficient; the keystone to coordinated and continuous services is a fixed point of responsibility so that, even though there are many agencies providing services, one remains responsible to see that all those services are delivered (Test, 1979). The case manager model was developed to do that job. There are a number of different case manager models; we like and use the team case management model, which we feel has several advantages for both patients and staff.

In addition to ensuring coordination, retaining responsibility for patient care means that the patient is not transferred or expelled from one program until he is well connected with another. I am sure all programs have patients who tax their limits, and sometimes a decision is made to stop working with a patient. We have a firm rule in our system that we cannot terminate our work with a patient until he is well connected with another program. If we cannot find another program, we continue to work with the patient until we do. Retaining responsibility also means we recognize many of our patients have lifelong disorders which require lifelong help. Thus, we make a commitment for *life* to a patient. The amount of service we may give during that lifetime varies tremendously. Some patients do so well that all they need is a phone call once a month just to find out how they are doing. Other patients require daily contact in their home, and for most patients the amount of input varies over time. To operate as efficiently as possible we try to give the patient just what he needs, when he needs it, and where he needs it. In summary, retaining responsibility is crucial, and it means ensuring that there is good agency coordination, that patients are not dropped from programs, and that treatment continues as long as the patient requires it.

*Working with the Family*. We believe that the families of our patients have carried a double burden for too long a period of time. They have carried the burden of having a member of their family stricken with a severe chronic illness, and unfortunately they have had to further cope with the burden of having mental health professionals telling them that they were responsible for that illness: that the mother is schizophrenogenic; or that the husband/wife relationship is pathological and resulted in developing a schizophrenic child; or that the whole family is sick and that the "identified patient" is carrying everyone's pathology so that the rest of them can appear well. Although these theories may be interesting, they are post hoc and have very little data to support them. The evidence in fact supports the notion that schizophrenia has a bio-psycho-social etiology with the

biological component being quite important. In any case, I do not think we are helping anybody, either the patient or the patient's family, by making them feel guilty or responsible for the illness. Cooperation of the family is frequently crucial in working with the patient, and family guilt markedly reduces cooperation. Often it is useful to separate the patient from his family, which is difficult to do in any case but almost impossible to do if the family is made to feel guilty. When working with families, we do the following: (1) We do our best to try to persuade them that we do not hold them responsible for the illness. (2) We try to assess whether it is useful for the patient to continue to live at home with the family (Greenley, 1979; Leff, 1976). In some cases separation is a good thing and in some cases it clearly is not. We use emotional overinvolvement, criticality, and intolerance as indicators as to whether to opt for a constructive family separation. (3) Whether we separate patients from their families or not, we continue to work closely with the family using a psycho-educational approach.

Whether the patient is living with the family or not, we have found that it is helpful to families *and* patients to provide education and support to family members.

## An Example of a System of Care for Persons with SLTMI

Dane County, Wisconsin, has a population of approximately 340,000 persons. Approximately 175,000 live in Madison with the remainder living in small towns and on farms. The county has identified approximately 1,500 individuals suffering from SLTMI and has creatively used funding mechanisms to develop a broad-based, multi-agency system of care, which has gained an international reputation for excellence. It is important to note that the system is *not* especially well endowed with funds to run a "model" program. In fact, Dane County receives less than the national average per capita for its mental health programming. There are primarily two factors which have made it possible for this county to provide excellent services to persons with SLTMI. First, it is the county's policy that its highest priority is to treat those in greatest need of treatment, i.e., persons suffering from severe mental illness and those in crisis. Secondly, it uses what funds it does have creatively to develop incentives for the service providers to treat this population in the least restrictive alternative. The major strategies to accomplish the above are budget strategies and comprehensive community programming.

## Budget Strategy

Limited resources cannot support both a large hospital population and a comprehensive system of community-based programs. Fortunately, the

availability of comprehensive community services dramatically reduces the need to use the hospital and produces a superior long-term clinical result (Stein & Test, 1980). In order to promote community-based services, Dane County contracts with a wide range of community-based providers for services with an emphasis on services for the SLTMI person and persons in crisis. In addition, the county is able to reallocate unused hospital dollars to support these community programs. To do this, the county budgets for anticipated inpatient costs based on the preceding year's usage. If actual inpatient costs are lower than projected, unused monies are funneled to existing agencies to increase community-based services. On the other hand, if inpatient costs exceed the budgeted amount, community program budgets are cut in order to pay for the higher inpatient costs. This is all possible because the dollar literally follows the patient (Stein & Ganser, 1983). If patients are hospitalized in any hospital including the state hospital, the county pays the bill. Contracting for services also makes the above procedure possible since the service providers are, for the most part, nonprofit corporation agencies, not county agencies, and thus are not protected by civil service. The jobs of the staffs of those agencies are literally dependent on there being sufficient money in the county's mental health budget to support their salaries. If the inpatient bill goes up, everyone is acutely aware that agency budgets will be cut and jobs will be lost. This fact provides real incentives to work with difficult patients rather than get them out of the system through long-term hospitalization. Short-term hospitalization is used when necessary, and since the need to use the hospital varies inversely with the comprehensiveness of community programming, the system for community care becomes self-reinforcing.

The county uses two monitoring mechanisms to keep hospital costs down. The first is the Crisis Resolution Services (CRS, which will be described in the next section) to act as gatekeeper of all patients on county monies who are admitted to the hospital. The county has given CRS the power to authorize or withhold payment to hospitals and attending physicians for inpatient care. The CRS screens all patients presenting for admission and either authorizes payment for inpatient care or takes over the clinical responsibility for treating the person in the community. Over the past seven years a high percentage of the potential hospital admissions have been averted. The other monitoring mechanism is to monitor treatment when a patient is admitted. Every county-funded hospitalized patient is assigned to a community-based service to monitor treatment while *in* the hospital. The monitoring agency works closely with the inpatient staff in both treatment of the patient and discharge planning. This ensures that length of stay is no longer than necessary.

These mechanisms of comprehensive community services, incentives, gatekeeping, and monitoring help keep hospital use at an appropriate level

and thus ensure there will be sufficient funds to support the comprehensive community-based treatment program necessary to help persons with SLTMI live decent and stable lives in the community.

## Comprehensive Community Services

As noted earlier, Dane County's mental health services are broad in scope and are provided for by a number of different agencies. The following are brief descriptions of some of the programs to give the reader a sample of what is available.

### *Crisis Resolution Services*

The Mental Health Center of Dane County provides 24-hour-per-day, 7-day-per-week crisis intervention through a mobile team which is available immediately to assist persons in crisis by going where they are. In addition to this mobile team, the Center operates a 24-hour-per-day telephone service which screens calls, and those calls which require the mobile service are transferred for immediate attention. Both the mobile team and the telephone team are trained personnel who are available at all times. Unlike most crisis intervention units, which see the patient for evaluation and then make a disposition (these units behave as "traffic directors" and often serve as a funnel into the hospital), the Dane County crisis unit is charged with the responsibility of resolving the crisis. They will stay with the patient until the patient is stable. This may require multiple daily contacts over several weeks. Once the patient is stable, he is then transferred into a continuing care unit. As noted earlier, in addition to the above, the crisis team is authorized by the county to act as gatekeeper for all county-paid hospital services.

### *Mobile Community Treatment Team*

This service is a direct replication of the Training in Community Living Program which won the American Psychiatric Association's gold medal award in 1974 as an alternative to mental hospital treatment ("Gold Award," 1974). It is a unit that specializes in working with the difficult-to-treat SLTMI person. The majority of their patients are young adult persons with chronic schizophrenia who are for the most part unwilling to come in for services and require outreach (Stein & Diamond, 1985a). Programming is individually tailored to each patient and consists of teaching patients daily living skills and working with them and community members and agencies to help the patient develop and maintain a support system. Being involved in some kind of work activity is an important aspect of the program and much is done with sheltered workshops, employers, and

voluntary job placements with charitable organizations. The program operates two shifts a day, seven days a week, with the crisis unit covering the midnight shift.

*Support Network—A Day Treatment Program*

The Support Network program is the Mental Health Center of Dane County's psychosocial rehabilitation unit for persons with SLTMI. The program has adopted many of the principles utilized by Fountain House. The program operates on a continuous routine basis for a scheduled portion of a 24-hour day and is dedicated to providing effective and comprehensive services to assist the SLTMI person in leading a more independent, healthy, successful, and fulfilling life in the community. The program works with the patients who generally are more stabilized than those patients served by the Mobile Community Treatment team. Nevertheless, this program provides case management services for its clients as well as outreach services.

*Living Arrangements*

The vast majority of the 1,100 persons with SLTMI living in Dane County are living in independent settings. There are, however, approximately 450 who are receiving specialized help with their living arrangements in a continuum from high structure to low structure. Most of these patients live in apartments which are visited by staff of the Special Living Arrangements Program.

*Inpatient Services*

Hospitalization is one important element in a comprehensive community support system. Crucial, however, is that the primary locus of care remains in the community even though the patient may be in a hospital for a short period of time. Dane County has for its use the psychiatric units of four general hospitals, a county hospital, and an acute unit of the state hospital. As noted earlier, the crisis unit acts as the gatekeeper for admission to all those units, and each hospitalized patient is monitored closely by a specific community service assigned to the case. In addition, a weekly list of inpatients is provided to key members of the system, who monitor lengths of stay very closely. As a result of these practices, patients in the hospital are not forgotten and hospital stays are relatively short.

The above description of programs is a brief encapsulation of a very comprehensive system of care. Only a portion of the programs that make up that system is described.

## Patient Characteristics: Influencing Selection of Service

A major systems problem is determining the kinds of clinical services that a particular patient needs in order to live in the community and identifying the program in the system that can provide those services. Grouping patients by diagnosis or even by the overall severity of their illness is less useful when making these decisions than thinking about the specific needs of individual patients. The Dane County system uses a typology that allows clinicians to think about patients on a number of different dimensions. Seven characteristics—willingness to come in for services, medication compliance, need for structured daily activities, ability to self-monitor, frequency of crises, need for professional psychological support, and degree of case management service required—are directly related to the kind of programming that each patient requires in order to live successfully in the community.

### *Willingness to Come In for Services*

Some patients in the system are unwilling to come in for services at all, while others are unreliable and frequently miss appointments. In many communities around the country these patients are called "unmotivated" or "treatment resistant" and are not treated until they become so sick as to qualify for involuntary hospitalization. In Dane County unwillingness to come in for services has been conceptualized as part of the illness; thus, it requires a specialized response. The specialized response has been to design a program especially for this population; among other things, the program has the ability to do assertive outreach. Obviously, a program that must go to patients requires a higher staff-to-patient ratio than a program that serves patients who are willing to come in for services.

### *Medication Compliance*

Patients who are not willing to take their medications regularly require a treatment approach that can monitor them very carefully and use a wide variety of incentives, augmented by legal coercions when necessary, to ensure that they take needed medication.

### *Need for Structured Daily Activities*

Many patients in the system have a social network of their own or a way of structuring their own time in a meaningful way and therefore do not require the provision of structured daily activities by a professional team. However, numerous patients in the system require special help in structuring their daily activities in order to experience their lives as meaningful.

*Ability to Self-Monitor*

Patients who can recognize that an increase in irrational thoughts and hallucinations is a signal that their disease is getting worse and that they should therefore seek help can be treated by a program that provides less intensive follow-along than for patients who are less able to self-monitor. Other patients respond to their irrational thoughts and hallucinations by staying in their rooms and discontinuing their normal social and treatment contacts. They often become isolated and withdrawn, and, if they are not intensively followed, they will emerge only when the symptoms become very overt.

*Frequency of Crises*

Patients who have frequent or severe crises need treatment from a program equipped to provide intensive and extensive crisis intervention. Patients who have few crises do not need such a program.

*Need for Professional Psychological Support*

Some persons with SLTMI have a well-established folk network that gives them sufficient psychological support to maintain stability. Many patients, however, require professional psychological support in order to maintain stability. These patients require more intensive services than the others.

*Degree of Case Management Services Required*

Some patients are able to negotiate complicated social and bureaucratic systems well enough not to require much specialized case management. Others require help in everything from budgeting money to shopping for food. Again, the intensity—and thus the cost—of services varies according to individual needs.

## Conclusion

Dane County, Wisconsin, has developed a comprehensive system of community-based programs for its citizens needing mental health services. There is a heavy emphasis in its programming for people in crisis and for persons suffering from severe and/or long-term illness. Programs for the SLTMI person are not time limited, and their goals are maintenance of stability and improving the quality of life rather than cure. Results have been highly gratifying. As noted earlier, of the 1,500 identified SLTMI persons in the county, over 75 percent live in independent settings, very few of which are of low quality. Case management is assertive, and few people get lost to the system. A range of community programs is available to meet the needs of the population. As a result, hospital admissions in

Dane County have dropped dramatically over the past 10 years, whereas for the United States as a whole hospital admissions have been increasing (Vischi et al., 1980). In addition, length of stay is short, further contributing to a dramatic reduction of hospital use in Dane County.

This system of care that is truly responsive to those in greatest need in our community would have been more difficult to develop if the mechanisms for controlling inpatient costs were not available. In the United States, on the average, 70 percent of the mental health dollar goes to support hospital services (Kiesler, 1980), leaving only 30 percent for community services, where the vast majority of the patients reside. In Dane County, on the other hand, only 15 percent of the mental health dollar goes for inpatient care while 85 percent supports community-based services. From our experience, one could argue that for many states there is sufficient money already in the system to provide good care if only that money were more rationally distributed. To accomplish this requires both a clinical policy to provide community-based services and a fiscal policy that provides real incentives to treat in the community.

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# Asylum and Community: Friend Not Foe

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We have been and currently are involved in the midst of a major evolutionary shift in the care and treatment of the seriously mentally ill in this country. At the outset, it is necessary to identify clearly the patient population that is being addressed in this paper, the seriously mentally ill: those people who have been diagnosed as having schizophrenia, bipolar disorder, major affective disorder, or mixed psychotic disorder. Throughout this paper, any reference to the mentally ill shall be to this more restricted, seriously impaired population.

Extraordinary forces are exerting tremendous pressure for change upon the public delivery system for the mentally ill and their families. It is important that we as concerned citizens periodically step back from the day-to-day issues, problems, and decisions to assess our direction, review the lessons of the past, set goals and objectives for the future, and make those midcourse corrections so critical to developing a delivery system of best fit. By a delivery system of best fit, I am referring to a system of care which is attuned to and blends the needs of the mentally ill; the issues of the family and the sociocultural environment within which the mentally ill person lives and is supported; state-of-the-art diagnostic, treatment, and rehabilitative technology, brought to bear to restore the mentally ill person to and remain at a productive, contributory level of functioning in society; economic exigencies of the day; and the zeitgeist and current political climate of the time. For the public delivery system, developing and applying state-of-the-art diagnostic, treatment, and rehabilitative technology can never, I suggest, take place in a social-political-economic vacuum. The system is constantly being adjusted, which impacts upon its effectiveness, efficiency, and viability in attaining its goal, the fullest possible restoration of the mentally ill. This paper adopts a position that I hope will stimulate the reader to challenge certain assumptions pertaining to the current public policy direction of the Texas system. We shall briefly review the history of the public mental health system's development, both in the nation as a whole and in Texas in particular, to identify those essential elements in the care and treatment of the mentally ill within the public sector. It is critical that these elements be identified and incorporated as the state system is redesigned and refined as well as that those techological improvements be addressed as they occur in the future.

The topic of this paper is "Asylum and Community: Friend Not Foe." As one reads this topic, perhaps an eyebrow is raised or a smile comes to the reader's lips. No doubt many a reader has a negative reaction to the topic—"Asylum." Everyone knows what asylum is; it refers to one of those monolithic structures that was created by society to warehouse our mentally ill citizens. It was a place usually stuck out in the country, away from the mainstream of society. It was a black hole, a place where mentally ill persons were placed, subjected to atrocities, and, often, never heard from again. It was a place that parents threatened to take their children when they misbehaved. It was a place spoken of in hushed tones. How can we be resurrecting the concept of asylum when we as a society have spent millions upon millions of dollars rending these institutions asunder and creating a new, innovative system in its place? Yes, but have we? Or, perhaps in our zeal, have we thrown out the proverbial baby with the bath water? There is no question that deinstitutionalization has been the most recent public policy initiative, which is to reduce and minimize the role of the state mental hospitals.

Perhaps it would serve us well, before proceeding further, to really define the term asylum. *Webster's New Collegiate Dictionary* provides the following definitions of asylum: (1) an inviolable place of refuge and protection giving shelter to criminals and debtors: sanctuary; (2) a place of retreat and security: shelter; (3) the protection or inviolability afforded by an asylum: refuge; and (4) an institution for the relief or care of the destitute or afflicted and especially the insane. Some of the key words in this list of definitions for us to store and remember are refuge, protection, shelter, retreat, security, inviolable—maybe we don't as fully understand this concept of asylum as we originally thought or assumed. Perhaps the concept was sound, but the implementation was defective.

Let us for a moment step back in time and briefly trace the development of the public system of care for the mentally ill and attempt to ascertain what went wrong. Was it really the concept of asylum that was in error or was the delivery system of best fit skewed by the forces of the time? It has long been recognized that a portion of the population has been mentally ill, virtually since the beginning of recorded history. Historical records refer to people who evidenced behaviors which in contemporary times would be diagnosed as a mental illness. For most of recorded history, mental illness has been poorly understood. Different cultures have reacted with, by and large, negative and prejudicial attitudes and approaches to the mentally ill. It is no doubt fair to state that from a historical perspective, mentally ill people have been scorned, punished, cast out, and abused—as an affliction of society. Perhaps these long-standing attitudes and prejudices in part explain why the care and treatment of the mentally ill has consistently been at the bottom of the funding barrel.

In this country, the case was no different. In the mid 1800s, Dorothea Dix recognized the plight of the mentally ill. She found mentally ill persons living in the worst, most deplorable situations of the day: in shacks and hovels, under bridges, and in jails, cast out or coughed up as undesirables to be kept off the streets so as to not bother society. This woman, one of the widely recognized pioneers in the care of the mentally ill in our country, began traversing the land. She gave voice to the concept of asylum for the mentally ill—a safe place away from harm where the basic life needs of food, clothing, and shelter as well as medical care could be met in as humane a fashion as possible. The concept caught hold, and state governments across the nation began to accept their responsibility for the mentally ill, building and operating state asylums.

In the young state of Texas, the growing and unresolved social problem of how to care for the insane was cause for concern and action. In 1856, Governor Elisha M. Pease established a committee to research the care and treatment of the insane throughout the country, evaluate the various approaches and technology, and develop a plan of care including the type of facility which would be best for Texas in order to address this problem. The committee, following extensive investigation, became enamored with and ultimately utilized a plan that had been developed several years earlier in Philadelphia, Pennsylvania, by the renowned Dr. Thomas Kirkbride. This new, progressive approach treated mental illness through a type of behavior modification, employed medications that were available at the time, and created a facility and environment for treatment that was relatively unrestricted. The plan called for facilities being constructed away from but accessible to the city of Austin with grounds that were parklike and attractive. Both the facility and grounds were to be spacious enough to accommodate the number of mentally ill persons that would be in residence and were to be flexible to expand as the population grew. In 1857, some 11 years after Texas attained statehood, construction was begun on the Texas State Hospital in Austin. The early population of the Austin facility began to expand rapidly, a problem that was addressed by the legislature by adding facilities in Terrell and San Antonio by the end of the century.

The early hospitals in Texas, like their sister facilities around the nation, suffered greatly as treatment and program plans were implemented. Although in concept the hospitals were to be treatment oriented, curative in approach, in reality the care provided was all too often custodial in nature. Limited funding and staffing coupled with ever increasing patient populations often resulted in what might be described as deplorable conditions.

On the national scene, in 1908 Clifford W. Beers, a former mental patient, published his famous and highly revealing critical book which dramatically and graphically portrayed his own hospitalization for mental

illness, *A Mind That Found Itself*. He began to crusade for improved, more humane and effective treatment of and therapy for the mentally ill. Shortly therafter, in 1909, stimulated by Beer's book, the National Committee for Mental Hygiene was established in an effort to improve the care of the mentally ill and to heighten the public's awareness of this condition. Even so, the mental health movement was slow in gaining impetus. Several events, however, occurred which provided major impetus to the movement. With World War II came an influx of new mentally ill persons, mental breakdowns that were induced by the stress of military combat, which served to heighten the public's awareness and concern for the conditions of care available for the mentally ill. In 1946 Congress passed the National Mental Health Act, creating the National Institute of Mental Health. The creation of NIMH established a focused point of reference and a public forum and direction for mental health issues in this country. Still, conditions for the mentally ill within state treatment facilities continued to deteriorate. In 1948 Albert Deutsch published his famous *The Shame of the States*, a revealing analysis of the care and treatment of the mentally ill at that time. The reaction of the public was one of outrage and a call for action. Action on a nationwide basis, public pressure galvanizing legislative action, is often slow in response. In large part because there was simply no viable alternative for the majority of the mentally ill in the country, the census within the state mental hospitals continued to swell. The efforts of Dix, Beers, and Kirkbride, the plans, hopes, and dreams, had been swallowed up as the mental hospitals came to be the only available alternative for the mentally ill with serious constraints imposed by both funding and technological limitations.

By the 1950s action was needed to alter the direction of the nation regarding the care of its mentally ill with over 50 percent of all hospital beds in the United States being occupied by mentally disabled persons. In 1955 Congress authorized the Joint Commission on Mental Illness and Health to undertake an extensive study of the nation's needs and resources for preventing and treating mental illness. A detailed report with sweeping recommendations and changes was submitted in 1961. The report called for an expanded federal role both in direction and funding, encouraging an expanded array of mental health services across the nation. A fundamental and basic shift in the care and handling of mental illness was envisioned—that care should take place in small, community-based centers. Shortly thereafter, the federally funded Community Mental Health Centers Act was passed establishing the mechanism to create a network of community mental health centers, public mental health care, nationwide.

Changes in Texas for the mentally ill basically paralleled these nationwide occurrences. By the time House Bill 3 was passed by the Texas legislature and signed into law by Governor John Connally in 1967, the

populations of the state hospitals had increased to almost 16,000 residents. House Bill 3, the authorizing legislation for the Texas Department of Mental Health and Mental Retardation, provided for the creation of a new system of care for the mentally ill of Texas, the development of the community mental health and mental retardation centers under independent boards of trustees. During the next 20 years, some 35 community mental health and mental retardation centers would be developed, covering the majority of the state's most populous areas, with the balance of the state served by the community services divisions of the state hospitals.

The development of the community mental health and mental retardation centers provided a new, innovative, interdisciplinary approach to the care and treatment of the mentally ill, all mentally ill, regardless of severity of condition. Both the federal and state mandates initially established the community-based system under broad, sweeping guidelines: develop a system of services which would meet the needs of all mentally ill persons. Utilizing an interdisciplinary team of professionals and paraprofessionals, incorporating a multimodal approach to the patient, a comprehensive, interlocking system of services was to be created under the guidance and direction of a local governing body such that diagnosis, treatment, and even preventative services could be tailored to the local needs and cultural nuances of the population within a specific geographic area. Diagnosis, treatment, and care were to be more state-of-the-art, more humane, less restrictive, more normalized, less disruptive to everyday life, more cost effective, less expensive—in a word, better.

The fledgling community-based system, flush with a wealth of new federal grant resources, began to do just what their mission statement established, designing and creating a comprehensive network of services for all persons within a region who were mentally ill. It is important to note that in many areas of the state, and the nation, the new mental health systems and programs at the community level were focused upon the less severely mentally ill, the walking wounded, if you will. New services provided on a sliding fee basis were suddenly made available for middle- and lower-income individuals and families as economic pressures and social changes placed increased strain on the population at large. Community centers branched out into a variety of areas, each addressing the local needs as perceived by the board of trustees and interpreted by the staff. No two centers were alike. The increased presence, expanded array of services, heightened community awareness, all resulted in new patient populations, increased expectations, local sources of financial support, and political attention for the community systems.

Unfortunately, what may have initially appeared to be a panacea for the mentally ill soon began to develop cracks in the very foundation. The federal grant program had been established by Congress as "seed money,"

a mechanism to start these new services which would then be picked up by state and local monies as the federal funds withdrew. As the federal funds began to decline significantly and the requirements for the funding mix to shift, increased pressures mounted at the state and local levels for increased financing of the community-based system. A major flaw in the federal initiative rapidly surfaced. Even with extensive preliminary planning and input, the federal program had not insured adequate involvement and participation of the states such that acceptance of the mission and ownership of the programs had been accomplished. The priorities of the state, especially in Texas, and those of the federal program were different and soon came into conflict. At the local level, mental health services had not been incorporated into the infrastructure of the traditional county and city core financial services. While mental health services had indeed been added to the list for funding and more support was generated than ever before in the history of the state for mental health services at the local level, the priority for and commitment to such funding was to a degree illusory, contingent upon the availability of ample tax resources. Community centers would find themselves in competition with both the bread-and-butter county and city services as well as with the other human and social services as the economy tightened in the 1980s. As federal support was rolled back in multiple areas, pressures upon state and local tax resources became intense. Services which had started to flourish, reaching out to all mentally ill, would have to be rolled back as necessary support was not forthcoming. Questions would begin to arise as to the permanence and stability of the community-based system and the commitment of the public policy makers to these services.

While the community service system was developing in Texas, an interesting phenomenon was quietly taking place within the state hospitals. New treatment technologies that were developing across the country were being implemented in the care and treatment of the mentally ill within the state. With the advent of the phenothiazines, psychopharmacology opened a whole new dimension in the treatment of the major mental illnesses. Thought disorders, wide emotional swings, and behavioral outbursts were now able to be controlled for a substantial portion of the mentally ill who had heretofore required long-term hospitalization. The hospitals began a quiet but dramatic shift: quality of care was important; the state hospitals for the mentally ill would become treatment focused. The hospitals started to discharge patients back to their communities and downsize their bed capacity. Lengths of stay were significantly decreased. Even persons who had had extensive periods of hospitalization were moving back to the communities. Increasing numbers of mentally ill persons, many of them evidencing a chronic condition, were coming home. Yet what were they

coming home to? What kind of system was in place to address and meet their continuing therapeutic and rehabilitative needs? Many community centers were providing very limited services for this population. The community centers had a broad mission to fulfill for the full spectrum of mentally ill and were faced with serious funding shortages. In fact, administrators and board members of some centers believed that the acutely and/or chronically mentally ill were in reality the "state's responsibility" and should be cared for in the large state institutions. To a large degree, the community centers and the state hospitals were not communicating with each other as they might be expected to within a treatment system. The community and hospital components became polarized; an "us versus them" attitude developed on both sides. Who was providing the "best" care became "the" issue. While these conflicts and issues played themselves out on a day-to-day basis, mentally ill persons were underserved. Former patients, without the necessary support and aftercare system, without adequate residential services, began to destabilize and develop a recycling, recidivistic pattern. Communities became alarmed. Families, where intact, were thrust into the role of the primary support system for the ex-hospital patient.

Both the Texas Board of Mental Health and Mental Retardation and the Texas legislature recognized the problem—a unitary, contiguous system of services was not developing in Texas. First in rule format and then in legislation, continuity-of-care expectations and requirements were enacted to establish a communication system and focused responsibilities within the components of the department toward developing a more patient-oriented system of services. Layered into this picture, a major federal class action lawsuit was filed in 1974 against the department, challenging the care and treatment of the mentally ill within the state hospitals of Texas. Basically, the lawsuit reflected that mentally ill persons should not be placed within a hospital environment and find themselves with inadequate care. If a person met the requirement for admission, was mentally ill under the terms of the Mental Health Code of Texas, he/she had a right to treatment and a right to be treated in a clinically appropriate, state-of-the-art manner. For almost 10 years the *R.A.J.* lawsuit lay relatively dormant.

Several legislative study and oversight groups were appointed by the legislature to investigate the department over multiple biennia, each identifying gaps and weaknesses within the system. The most recent panel issued the Legislative Oversight Committee Report in 1984, which encompassed extensive recommendations which ultimately led to the passage of Senate Bill 633 in 1985. S.B. 633 mandated that the department identify priority populations for services and established that funds provided by the legislature were to go first and foremost for these patient needs. A minimum set of five essential CORE services was created by the

law with the requirement that these must be established within each of the mental health authority regions. Mental health authorities were created as the entities responsible for the public system at the community level. In 1987, the Sunset Bill for reauthorization of the department further reinforced the direction established with S.B. 633: the mission of the system funded by the state through the Texas Department of Mental Health and Mental Retardation was altered, refocused upon the priority populations as established by the department. The focus would be upon the most severely mentally ill. In addition, CORE services were expanded, community MH/MR center funding was redefined in the form of contracts for service, and community service divisions of the state hospitals were established as virtually identical in terms of CORE service and standards requirements. The state funding system, including federal flow-through block grant funds and matching local monies, was clearly redesigned.

As the department moved into the early 1980s, the *R.A.J.* lawsuit was settled by the state, and a court-appointed panel was established to monitor compliance and interpret the settlement agreement conditions. The impact of the lawsuit upon the system began to be experienced. By the 1980s all of the state hospitals in Texas had attained Joint Commission on Accreditation of Healthcare Organizations accreditation, which became a part of the lawsuit compliance monitoring. The lawsuit focused upon staff-to-patient ratios, professional staff involvement and credentials, psychosocial rehabilitative programming, staff training, and pharmacotherapy, to list but a few of the major areas impacted by the suit. The lawsuit monitoring process during the late 1980s has begun to look at the care provided at the community level to persons who have been discharged from the state hospitals.

Through this myriad of changes which have been occurring in the care and treatment of the mentally ill in Texas over the past almost 40 years, what has happened to concept of asylum as envisioned by Dorothea Dix? Has the public system for the mentally ill created this safe place, this place away from harm where basic life and medical needs are met? Have the public policy makers of today committed the necessary resources to provide safe, adequate, appropriate treatment and rehabilitation as was initiated in 1857?

Let us attempt to review the current system in its efforts to approximate or attain asylum for the mentally ill. While it is clear that the state hospitals during the first half of the century had become the problem, rather than the solution, a transformation has taken place in the last decade, a virtual metamorphosis. The hospitals have become acute care, tertiary inpatient facilities—diagnostic and treatment-focused systems. In response to reduced patient census, increased funding and staffing, increased commitment to quality of care as reflected in attaining JCAHO accreditation,

pressure and monitoring by the *R.A.J.* lawsuit panel and consultants, and the refocusing of the community-based service delivery system, state hospitals have more closely achieved a level of care which may be deemed as providing asylum for the mentally ill than ever before. There are key elements in this picture which become essential to discussing the application of the concept and the actualization of asylum at the community level.

Perhaps, first and foremost, the hospital provides a safe haven from the illness itself. Recognizing that the very nature of the illness often precludes the mentally ill person from being aware of his/her own difficulties, the individual is generally admitted to the hospital under an order of the court, a legal umbrella which ensures that diagnosis and treatment are provided within a prescribed time frame. The legal umbrella prevents the mentally ill person from aborting or interrupting the care prior to attaining a level of stabilization and integration wherein the person is no longer deemed to be dangerous to him/herself or others. The court order recognizes that the mentally ill person is often not able to make a constructive, informed judgment with regard to decisions concerning his/her illness and places those decisions in the hands of a trained professional staff. The ward environment is staffed in a manner that allows rapid intercession if a patient loses control in order to prevent the patient or others from being placed in physical jeopardy. External environmental pressures and issues are restricted and controlled, limiting access and exposure until the individual begins to demonstrate the internal resources to deal with them.

*Diagnosis and Treatment*: Upon admission, the patient receives a comprehensive assessment by an interdisciplinary professional team which addresses the individual's psychiatric, psychological, social, and vocational-rehabilitative needs in addition to a thorough medical, dental, and laboratory workup. Based upon findings of the assessments, an array of psychosocial, rehabilitative, and pharmacological services is brought to focus upon the patient according to an individualized, prescriptive treatment plan and case formulation. The treatment team, under the direction of a staff physician, usually a psychiatrist, can rapidly initiate treatment to begin to calm or control the most florid of the patient's symptoms. Some relief from the turmoil, confusion, and anguish can begin to occur. Timely blood chemistry analyses provide the physician with data to ensure that medications are prescribed in an effective, therapeutic, and appropriate manner. Ongoing, careful monitoring of potential side effects occurs. Medications are administered by licensed personnel to ensure that they are taken as prescribed. As the uncontrolled thought or affective symptoms of the illness begin to abate, individual and/or group counseling, occupational therapy, vocational-educational-rehabilitative services, and family and ministerial support are prescriptively provided for the patient. If during the medical assessment specific physiological anomalies are identified, an

array of consultant specialists are involved with the case for additional diagnosis and treatment.

*Life Support Needs*: The hospital ward environment provides reasonable living accommodations in a group setting. Within the ward setting, each patient is provided his/her own bedroom-living area with personal linens. A balanced, nutritional diet is provided with capabilities for special dietary needs accommodated. Clothing is available if the patient is indigent and in need of basic clothing upon admission. Laundry service ensures that clothing and linens are maintained in a clean and usable fashion. The external elements are well controlled making the living arrangements comfortable for the patients.

*Time, Space, and Structure*: The hospital staff recognizes and adapts to the nature of serious mental illness and its negative impact on the patient's orientation in time and space. Upon admission, a highly structured ward routine with a staff system of prompts for schedule attendance is provided to ensure attention to life support and therapeutic needs and activities including supervised transportation around the campus. As the patient begins to reconstitute, greater flexibility and self-determination is extended through external privileges. A variety of recreational, social, and leisure time activities is available to the patient in an effort to reintegrate the person into social, interpersonal relationships and provide meaningful and enjoyable activities, tapping into areas of personal interest and talent, which may be continued in the community after hospitalization is completed.

The hospital provides what amounts to a therapeutic cocoon—a protective, therapeutic, and life support shell that accommodates, flexes, and adjusts to and with the progress in the patient's illness. Through the individualized, prescriptive planning process, the interdisciplinary professional team continues to monitor, adjust, and refine the services and structure of the hospital as brought to bear on the patient at a given time. The staff assumes the role of patient advocate and case manager to ensure broad oversight of this process and attention to the spectrum of patient needs.

If this therapeutic cocoon created by the hospital resources appears to be ideal and to have met fully the criteria for asylum, it does not. Clearly the state hospitals in Texas of the 1980s have shown dramatic progress in terms of professional and paraprofessional staff coverage; availability of services; broadened, more comprehensive treatment and rehabilitation of the patient's psychiatric and physical condition(s); improved facilities; better trained staff at all levels; and improved quality of care. On the other hand, my descriptive analysis of the hospital program does not apply uniformly either within or across hospitals due to funding limitations and constraints at this time. In addition, the hospital environment, if not carefully

monitored to stimulate self-sufficiency and independence within the patient, can be most seductive and result in an institutionalized, dependent personality.

One of the major deficiencies in the critical elements for the concept of asylum is that of time—the capability to maintain the most seriously involved within the therapeutic setting over protracted periods with movement toward independent functioning occurring in very small, measured steps. Our state hospitals have shifted from custodial care to curative care wherein substantial pressure is brought to bear upon the treatment team and the patient to move out of the facility back to community life at the earliest possible point, as soon as the professional determination is made that he or she is no longer dangerous. The patient may, in fact, still show evidence of illness or aberrant behavior, may not be fully or securely stabilized, may not be as fully aware of his/her illness and the necessary aftercare/outpatient services needed to maintain this stability. Thus, one of the essential elements for asylum is still lacking, that the treatment program cover sufficient time to permit the chronically mentally ill person to be securely stabilized, to be educated with regard to his/her condition, and to become committed to the steps necessary to maintain this stability. The person must have time to develop the internal strengths and skills necessary to approach and interact with the problems of contemporary society. The pressure of limited resources and legal directives tends to thrust the severely and chronically mentally ill back into the community for continued care and assistance. In addition, too often today the public mental health system has been forced to rely on the family, where intact, as the primary means of maintaining and supporting the mentally ill person instead of the community-based system's being sufficiently and adequately funded to provide the array of services necessary to continue or extend the therapeutic cocoon to community living.

The move from hospital-based to community-based care is often severe and dramatic. This shift requires that the patient be capable of sustaining one of the most traumatic changes, which may, for the most severely impaired, be too great for them to adjust successfully in a way that they may continue the course of treatment and rehabilitation for successful reintegration into community life. What does a recidivism rate of 40 to 50 or even 60 percent indicate in terms of the system's design? It may mean that the community system is currently inadequate to support a substantial portion of the severely mentally ill and that the gaps between community and hospital care are too great, or perhaps it means that the hospital is not devoting sufficient time and prescriptively tailoring the steps toward independent functioning in small enough bits such that the patient can adjust to and transfer the therapeutic knowledge and progress from the hospital setting. Have we in our zeal as a society to ensure the rights of the

mentally ill as well as correct the inadequacies of the hospitals as institutions returned the mentally ill to the societal environment of 100 years ago? Have we now overloaded an underfunded, underresourced community system under the guise of state-of-the-art care today?

From the protected, secure, structured environment of the hospital the patient is thrust out into the real world wherein little of the treatment, rehabilitative, and support systems are coordinated, integrated, or readily accessable to the patient. In fact, just the contrary exists. Most often, the pieces of the community-based system that would constitute asylum for the patient are fractionated, under the purview of different agencies or organizations, each struggling in today's economic climate. From an integrated system of services, the patient upon discharge is expected to rather independently weave his/her way through a minefield of rules, regulations, appointments, and locations to replicate the hospital's therapeutic cocoon. In spite of what we know about the mentally ill, particularly those with a history of chronicity—that they often have a cyclical illness pattern, do not recognize their own illness, reject continued treatment/aftercare, stop their medications, have difficulty with time and place, have limited frustration tolerance for rules and regulations, have difficulty transferring knowledge or skills across different situations--we all too often require that these very skills be present in the patient upon discharge to continue care via community resources. And we wonder why so many of them currently fail and recycle back to the hospital.

What is now needed is the next step in the evolutionary development of the public mental health system—the fleshing out of the community-based system to provide asylum within the community. The therapeutic cocoon can be extended to and created within the community and meet the continuing needs of the mentally ill across the continuum of time. To do so requires a level of commitment both by the public policy makers and by the community-based system caregivers. We must either fund the components of asylum within the community mental health system or mandate shared responsibilities among the several agencies which currently provide the services necessary to complete the system of care.

The pieces are relatively simple to define but in actuality difficult to deliver. At the point of discharge, or furlough, from the hospital, an immediate linkage with the community support system must be present on a continuing basis during the early days post hospitalization in the form of a case manager spending as much time with the patient as needed and desired. The case manager becomes the professional friend, ally, and advocate for the mentally ill person. This is the individual representative of the agency to whom the mentally ill person can bond as the caring, coordinating, facilitating link across the various components in the system or across agencies composing the system. This position becomes the

extended structure of the hospital, the prompter, ensuring that the mentally ill person establishes those ties and receives those services on schedule as defined within the discharge community support plan. The case manager should meet with and begin to establish the relationship with the patient prior to transfer from the hospital.

An interdisciplinary professional team must be available to provide and oversee the community treatment and rehabilitative program including counseling and education, psychosocial day/evening programming, vocational and/or sheltered work experiences, and psychopharmacological services. Medications must be provided if the individual cannot afford to purchase them, and a supportive structure must be available to ensure continuing compliance with the medication regime as prescribed, or modified, by the physician, while monitoring for potential negative side effects. Periodic laboratory monitoring to ensure therapeutic dosage is necessary. Crisis intervention and stabilization services must be readily accessible if deterioration begins to occur. In addition to the psychiatric components of care, the community asylum system must have ready access to and periodic but regular involvement with general medical and dental services for the patient. Too often the mentally ill do not receive adequate and timely medical or dental services either because of funding issues or because those community providers tend to discount their reports by attributing their complaints to their mental illness, often being uncomfortable with the patient and wishing to avoid participation in their care.

Basic life support needs may become critical for the mentally ill in the community. Adequate housing—with basic furniture, linens, and utensils—with graduated supervision and structure as clinically indicated should be available. Nutritional considerations including assisted shopping and food preparation may be needed. Utilities assistance and oversight is essential to ensure that the utility bills are paid each month and that the living environment is maintained in a sound, comfortable, and safe condition. A financial support mechanism to assist the patient to assume a level of control over his/her own life support needs must be in place until the patient is able financially to be independent and responsible for him/herself. This financial mechanism must be secure enough to avoid continuing threat of disruption or discontinuance, which generates significant anxiety and threatens the stability of the patient. Financial planning and education must be a part of the support system in order to develop the ability for the patient to manage his/her life on a limited income.

The community mental health system must recognize the social and personal needs of the mentally ill and provide alternatives and opportunities for these people to socialize in a comfortable manner. Drop-in centers, social events, community activities, church participation, all become a part of the network of services and activities for community-based asylum.

Mentally ill people become lonely; they feel abandoned, rejected, lost, upon leaving the hospital. So many of them tend to withdraw, which further compounds the problem, pushing them toward destabilization. A critical issue with the social-recreational support system is the need for transportation. Even where public transportation is available, the mentally ill person will need assistance in the beginning to learn or relearn the routes and feel confident to maneuver around the community. Where public transportation is not available, mechanisms need to be established to facilitate that person's participation in the community social-recreational events and activities. Additionally, the mentally ill often need a boost, a helping hand, to participate because of their own anxieties, concerns, and/or questions of self-worth.

The final area that needs to be mentioned deals with the legal umbrella which recognizes and addresses the mental illness itself and provides that oversight for the individual such that if the person begins to destabilize intervention may be brought to bear. The provisions of the existing Mental Health Code need to be more fully understood and utilized, such as outpatient commitment or extended furloughs from the hospital, depending upon the patient's clinical history. New legislative mechanisms may need to be created. Individual or nonprofit corporation mechanisms may need to be established to provide an umbrella of guardianship or limited guardianship. An effort needs to be made to prevent emotionally destructive and traumatic reexacerbations of the illness resulting in reoccurring commitments to the hospital. The cycles need to be anticipated and stabilization services provided before the patient crashes and burns.

To restore and rehabilitate mentally ill individuals will require the resources to implement a system that blends community and hospital environments into one therapeutic cocoon—asylum as envisioned by Dix and Beers—but updated through the technology and understanding of today. Small, finely tuned steps in a treatment/rehabilitative system that is integrated and communicates freely and completely between the different components is essential. The community-based mental health system will require a vast network of resources, providing more normalized, less restrictive services as the patient progresses. It should be noted that decentralized, indigenous community services may potentially cost more as a total treatment/support system than hospital per day costs in the future as one ensures comprehensive and coordinated care and loses the cost-containing advantages achieved through economy of scale in the hospital system. Hospitals may need to develop small, cottagelike facilities on the grounds for the most psychiatrically fragile and/or chronically mentally ill who may have to reside for many years in this extended rehabilitative residential environment, taking much more limited steps to make the transition out of these surroundings and into participation in community

activities as the patient successfully demonstrates tolerance for community participation.

Each step in the treatment-rehabilitative process should be prescriptively tailored to and for these patients, whether in the community or the hospital. Caution must again be exercised to provide the cocoon with enough tension so as to encourage independence and self-sufficiency. Monitoring to prevent institutionalization must be a part of the ongoing review process.

The mentally ill are a complex, heterogeneous population with varying and divergent needs. The course or nature of this illness for the most impaired tends to be cyclical with periods of relative stability coupled with those of deterioration and reexacerbation of the illness. Such is our knowledge and technology today that success and restoration of the mentally ill in our complex, pressured society within realistic budgetary constraints may only be realized through the blending of community and hospital resources and services, tailored to the individual in as cost-effective and clinically appropriate a fashion as possible. The continuing evolution of the public mental health system must ensure an integrated, contiguous network of services, both within and across agencies, for the mentally ill and their families, designed in such a manner as to accommodate the next generation of improved diagnostic and treatment methodologies, which are clearly on the horizon. We need a blueprint for a system of care that incorporates the fundamental elements of asylum in both community and hospital settings, that adjusts to the individual patient and innovations in care, and supports the family structure within which the mentally ill person resides.

To do otherwise is to truly come full circle, with the mentally ill significantly present among the homeless, living in squalid conditions, staying under bridges, being incarcerated in jails and prisons, instead of being treated. The tragedy is most simply in not implementing what we know will be effective. Just as asylum can be created within the community setting as well as within the hospital environment, the converse is also true. Institutionalization, with all the negative elements that became associated with the early mental hospitals, can be replicated in the community: overcrowding within inadequate living conditions; minimal, poorly trained personnel; abusive, neglectful, and countertherapeutic environments; inadequate, inappropriate diagnosis and treatment; and the people themselves buffeted by the illness as opposed to being productive, contributing members of society. In our efforts to deinstitutionalize the mentally ill, we may one day wake up and find that we have reinstitutionalized them, but in the community. Defining and evolving the system requires that we recognize and accommodate the nature of the illness, provide quality, comprehensive diagnostic, treatment, and rehabilitative services, and

ensure continuity of care and communication across and between the various components of the system. Assisting the mentally ill individual to become all that he or she can be—can we as a society afford to do anything less?

# State Agency Collaboration on Mental Health Issues from a Political Perspective

**Ray Farabee**, *The University of Texas System*

**"Interagency collaboration" is the buzzword of the 1980s. It's a case of "When all else fails, collaborate."**

**Why?**

*Because society and government have become incredibly complex.*

Decentralization of power is one of the fundamental aspects of our democracy. We are suspicious of anything reeking of "big brother"-ness. But with that decentralization comes the dispersion of power and complexity of the system we live in now.

Several layers of government—federal, state, county, and local—deliver services to people. Within each layer, several different agencies deliver special kinds of services in several different ways (via direct delivery, contracted services, referrals, etc.). And as anyone who may have ever dealt with *any* agency for *any* purpose knows, each agency is in itself a convoluted microcosm of our exceedingly complex society. (Just *try* to find out something from the IRS and you'll know what I mean!)

*Because we live in the Information Age.*

Computers are fast replacing the ballpoint pen, the memo, and the telephone as our major means of communication within government. With computers, we have capabilities that we've never had before to coordinate within and between mega-agencies and within and between levels of government.

*And last, because we're broke.*

Policymakers like to make policy, to push the system forward. When there is no money for new programs, we call for coordination of efforts. Coordination can vastly improve the service delivery system. It also gives us some positive steps to take when we don't have any money.

**Misconceptions about interagency collaboration are common.**

*Each agency exists in a world unto itself. There is absolutely no collaboration at any level.*

Although much the collaboration across agency and unit of government lines that occurs at the top levels of administration has been prodded by legislative or judicial mandates, collaboration occurs every day at the service delivery level.

A case manager in a community mental health program talks to the Department of Human Services office to arrange food stamps for a client, to the county-run public hospital to obtain health care, and to the local rehabilitation office to arrange training.

A state hospital outreach substance abuse worker drives a state van full of clients to and from the community center's halfway house for therapy funded by the Texas Commission on Alcohol and Drug Abuse.

A Department of Human Services caseworker procures therapy from a community mental health center for an abused child and works with the local school district to arrange speech education services.

By necessity, service delivery staff work with several agencies. As one state hospital social worker stated to me, "Those of us dealing with clients don't pay attention to where our fellow workers get their paychecks. We just do what is right for the client. Why can't those guys in Austin do likewise?"

*Collaboration is necessary because there is a great duplication of services in state agencies.*

As those who work with the mentally ill in Texas know, our problem is *not* one of overlapping services. It is one of huge *gaps* in services.

In areas where two state agencies may provide similar services, such as substance abuse treatment funded by TDMHMR, by a community MHMR center, and by TCADA, there are more than enough clients to go around. In fact, we still make hardly a dent in addressing the needs of the populace.

And in other areas, different agencies may serve the same clients, but they provide distinctly different services that combine to form a system of care. For example, the Texas Rehabilitation Commission may provide work training, Department of Human Services may help with Medicaid eligibility, and TDMHMR may provide treatment to the same person with mental illness.

*Consolidation of agencies is the best means of forcing interagency collaboration and closing gaps in the service delivery system.*

The lure of agency reorganization is strong among lawmakers. Consolidation of several agencies under an umbrella, the most radical type of reorganization, is often suggested as a means of closing gaps in the service delivery system and of eliminating waste, thereby improving services and saving money at the same time.

Unfortunately, it doesn't work as planned. Florida is a prime example of the failure of agency consolidation. In 1975, the Florida legislature consolidated its health and human services agencies under one umbrella, the Department of Health and Rehabilitative Services, in an attempt to integrate social services at the client level. As you can imagine, passage of the legislation and implementation of the consolidation took enormous political and administrative energy and caused a great deal of turmoil for service providers. Yet, after a decade of experience with the new system, most observers agree that Florida is no closer to service integration than it was before the consolidation. And several principles have become evident:

- Consolidation does not close gaps in services. It merely transforms the disparate divisions within an agency, leaving the same configuration of services at the client level that existed before consolidation.
- Consolidation does not save money. Again, the original agencies remain basically intact; they merely become large unwieldy divisions within a single agency.

  Also, because lawmakers expect consolidation to save money, they may cut appropriations based on the consolidation, as happened in Florida. The end result, of course, is that services, not administration, are shortchanged.

  This is an especially critical point from a political perspective, because advocates for efficiency in government are typically more powerful and represent a greater political constituency (i.e., *all* taxpayers) than advocates for improved human services.
- Consolidation used as the first tool to elicit change distracts the agency staffs from their mission and causes a focus on structure over goals. Real change comes from clarity of goals, broad participation in policy-making, and strong accountability measures.
- Complex problems such as delivery of human services probably require complex organizational structures. Thus, maybe we're better off with the kind of system we have now involving several different agencies at every level of government.

**How collaboration, as opposed to consolidation, can work:**

Collaboration *does* improve services because it fosters communication at all levels of agencies, allows joint planning efforts, and enables service providers to begin to close the gaps.

There have been two recent examples of successful collaborative efforts in services to people with mental illness.

- *Robert Wood Johnson grants for services to the chronically mentally ill.*

  The Robert Wood Johnson Foundation awards millions of dollars in

grants for pilot projects, all of which encourage the design of a coordinated system of care organized at the local level.

The driving concept behind all of these grants is that services must be organized around the client and that localities can create a sound system of care by fostering interagency collaboration among all pertinent local service providers, whether they be branches of federal, state, or local government or private providers.

I served on the site visit team for the Robert Wood Johnson grant for services to the chronically mentally ill and visited several applicant sites in the summer of 1985. Grant applications were signed jointly by the administrative heads of all agencies involved, so not only did the local service providers coordinate their efforts but the top levels of administration of each involved agency were pulled into the collaboration. In many instances this was the first time some of the participants had ever sat down and talked to each other about serving the chronically mentally ill. Thus, the application process itself served a useful purpose.

Grant recipients are now implementing model programs that provide HUD low-cost housing, outreach, and treatment for the population that has traditionally fallen through the cracks. Austin-Travis County MHMR Center is one of only nine grant recipients in the nation. Its experience should provide valuable lessons for the rest of our system in providing care via interagency collaboration, as bridges have been built between providers that had never before worked so closely together.

- ☐ *McKinney Act grants for services to the homeless mentally ill.*

  This national legislation provides block grant money to states for serving the homeless mentally ill, and like the Robert Wood Johnson grants it requires providers to create local systems of care. Thus, there is coordination between housing authorities, vocational rehabilitation offices, shelter workers, community MHMR centers, state hospitals, and local public hospitals.

**What it takes to have effective interagency collaboration and improve services to the mentally ill:**

There are two fundamental elements necessary to the fostering of effective interagency collaboration—strong leadership and unity of vision.

- ☐ *Strong leadership*

  Collaboration is easiest in those states that have a strong governor/cabinet form of government, because the governor has more control over agencies and can direct collaborative efforts.

  In Texas, we obviously do not have this type of government.

  Thus, collaboration requires joint efforts by the governor, lieutenant governor, and speaker. All recent instances of interagency coordination

have come about as a result of this joint leadership. Take, for example, Medicaid expansion. It has been called for during the last several sessions, with no results. Finally, as a result of strong leadership, we have expanded Medicaid to pregnant women and children up to the age of two. Perhaps in the near future we can take advantage of opportunities for other expansions, including services for the mentally ill.

- *Unity of vision*

  All too often, governmental and budgetary decisions are made in response to crises—either fiscal or human. Thus, we never decide just what the government should do for its citizens and how it should do it—we just make Band-Aid repairs to a system that has evolved historically. Hence, the terrible gaps continue.

  What is needed to have the most effective system and to make the most use of interagency collaboration is an analysis of the needs of our citizens and a unity of vision on how we will address those needs, irrespective of the system that has evolved over time. Once we have a clear understanding of what we want our service system to be, we can begin to figure out how to move the current system toward the idea.

**What the state is doing now to improve interagency collaboration for services to the mentally ill.**

*Health and Human Services Coordination Council's study of health and human services programs:*

Last December, Governor Clements, Lieutenant Governor Hobby, and Speaker Lewis gave the Coordinating Council the task of studying how to improve service delivery and to maximize resources. Then, last session, the legislature passed HCR 36 establishing the Committee on the Reorganization of State Agencies.

Because of the Council's charge from the leadership to study health and human services agencies, the HCR 36 Committee is not considering reorganization of health and human services agencies; they will instead rely on the recommendations made by the Coordinating Council.

Rejecting the notion of consolidation of health and human services agencies because of the failure of consolidation in other states, the Council is focusing on two things: coordinated data collection and a state strategic plan for delivery of human services. All agencies will report needs data to the council on the basis of COG (Council of Government) boundaries, enabling us for the first time to determine needs across traditional agency boundaries. All agencies will also submit their strategic plans to the Council, and these will be compiled into the first statewide master plan for delivery of human services.

*Children and Youth Services State Coordinating Committee:*
Established by the TDHS Sunset Bill, this committee is studying coordination among all agency programs relating to children and youth.

*Legislative Oversight Committee on Substance Abuse:*
This committee is making recommendations regarding coordination among the 11 state agencies that deal with substance abusers.

*Senate Select Committee on Juvenile Justice:*
This committee is charged with making coordination recommendations to improve services to children involved in the juvenile justice system as well as to improve services to children overall in an attempt to reduce future delinquency.

*Transition Services Task Force:*
This task force is assessing the effectiveness of existing services for helping people with disabilities become self-sufficient in the community.

*Interagency Council on Mentally Retarded, Developmentally Disabled, and Mentally Ill Offenders:*
This council is charged with making recommendations for serving these special populations and will consider expansion of the Mentally Retarded Offender pilot project, which involves close coordination between several agencies at the local level, including MHMR, the police, the courts, and educational systems.

*Interagency memoranda of understanding:*
Just from last session, TDMHMR is involved in establishing more than a dozen memoranda of understanding with other agencies regarding long-term care, multi-problem children, expansion of Medicaid, genetic services, abused children, and other specific populations.

*TDC/TDMHMR cooperation in treating mentally ill offenders at Rusk State Hospital:*
In order to enable the Texas Department of Corrections to establish a psychiatric unit for mentally ill prisoners, the legislature last session moved TDMHMR's maximum security unit from Rusk State Hospital to Vernon State Hospital and turned over the secure unit of Rusk to TDC.

**Final note:**

The mentally ill population is becoming more and more complex as time goes on, and we are seeing more of the young chronically mentally ill who

need services but have not been institutionalized and are not compliant like the generation of people with mental illness before them. These people are challenging our service delivery system and forcing us to become more flexible in our thinking.

Where before we used state hospitals to provide housing, treatment, and some sort of social experience to people with mental illness, we now are challenged to develop more appropriate, more humane systems of care that integrate people with mental illness into society as a whole. We need crisis stabilization units—these require cooperation between mental health professionals, law enforcement personnel, and public health systems. We need outreach to the homeless mentally ill—this requires cooperation between housing authorities, mental health systems, police, shelter organizations, churches, food banks, and social service organizations. We need special programs for multihandicapped children—these require cooperation between mental health workers, school districts, and health providers.

The significant thing about all the efforts so far is not that they have revamped organizational structures or torn down existing systems and replaced them with new ones. It is that they have gotten people talking to each other. Forming coalitions that break traditional agency barriers is the first step in closing the gaps through which so many mentally ill people have fallen.

# Intrafamily Conflict and the Delivery of Mental Health Services: Whose Rights Prevail?

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Everyone can agree that the ideal environment for the delivery of mental health services involves a situation where there is a high degree of cooperation among the service providers, the family, and the direct recipient of these services. Unfortunately, however, the attainment of this goal is often difficult, if not illusory. In the all too common situation when there is a disagreement among family members, the delivery of mental health services tends to suffer. In the case of adults, the autonomy of the individual tends to prevail. However, in situations involving juveniles, the state has intervened strongly in many jurisdictions including Texas on the side of the parents. Thus, while the pendulum has swung in favor of individual autonomy concerning adults who receive or need mental health services, there has been a swing in the opposite direction with regard to minors, in favor of parental rights.

During the first half of the century mental health services largely were limited to commitment to a state institution. Mental hospitals generally were placed away from large centers of population. They could be found in sleepy state capitals or in rural areas. The phrase "out of sight—out of mind" aptly described the situation. There were private facilities, of course, but the number of individuals served at these locations paled when compared to the state hospital. In addition, general practitioners provided some assistance for those individuals who resided in the community. The stigma of mental illness was prevalent. Persons admitting to mental illness faced discrimination in employment and other facets of life, and family members felt ashamed.[1]

(Parenthetically, we can feel no great sense of accomplishment in removing the stigma even today. In 1972, an individual who had a distinguished career as a United States senator was forced off the Democratic party ticket when it was discovered that he once had received electroconvulsive therapy. It appears that attitudes have not changed in the ensuing 16 years. The reaction of the press and public to the possibility that Governor Dukakis might have sought professional help for depression following his brother's death and his own defeat for reelection to the governorship of Massachusetts provides ample evidence that the stigma of mental illness remains with us today.)[2]

The commitment statutes matched the prevailing attitudes concerning the mentally ill. The most common form of commitment was one that was indefinite in duration. A single hearing could result in long-term involuntary hospitalization. Furthermore, individuals would lose most of their civil rights by being committed to a state hospital. Commitment essentially was a finding of incompetency as well as an order of confinement in an institution. The statutory standard was minimal. Evidence that a person was "mentally ill and in need of treatment" often was sufficient. Rarely were there hearings in any meaningful sense. The next of kin often was given wide authority to waive rights on behalf of the not yet committed.[3]

There was a major wave of reform during the 1950s. Statutes were strengthened, providing more in the way of due process rights for individuals facing commitment. However, the indefinite commitment was still the most common form of judicial order of hospitalization, and new statutes did not serve as a solution for sloppy procedures. For example, a 1966 study of Travis County, Texas, revealed what was essentially an assembly line form of justice. There were mass commitments, hearings were nonexistent, and attorneys did little but go along with the system.[4]

It was only a matter of time until the due process revolution which had affected other areas of American life finally was brought to bear on the situation of the mentally ill. In 1972 Justice Harry Blackmun of the United States Supreme Court commented in an opinion that states traditionally had exercised broad power to commit persons found to be mentally ill. "Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated."[5] If this aside was meant to be an invitation to bring lawsuits, Justice Blackmun was successful. In state after state the procedural rules, the substantive standard, and the level of care all became the subject of ongoing litigation.[6]

Texas was not spared. The United States Supreme Court used a Texas case as a vehicle to announce that the standard for commitment of an individual had to be greater than that used in a case involving a car accident. From now on, the state had to prove every element by clear and convincing evidence. (By the time of the decision, only Texas and Mississippi had stubbornly maintained that the preponderance of evidence standard was sufficient.)[7] The well-known Texas case, *R.A.J.*, began in 1974 and remains active even today.[8]

Legislatures were not silent. Heeding the suggestions of state and federal courts, lawmakers amended state mental health codes during the period of the 1970s. Texas, for example, added the outpatient commitment, recognizing that individuals could receive necessary services in the community rather than in an inpatient facility. More care was given to the hearing process, although the level of attention was rather uneven.[9] These changes

did not happen in a vacuum. At the same time, new developments in the treatment of the mentally ill were having their effect. Phenothiazines, introduced in the 1950s, were widely used by the 1960s and had become standard treatment by the 1970s.[10]

There was a general consensus that many state inpatient facilities were substandard, but there was no consensus concerning the solution. Some advocated closing down all facilities, while others urged better facilities. The net result was a shaky compromise in which deinstitutionalization became the norm. The number of inpatient beds shrank dramatically during the decade of the 1970s. However, the population did not disappear. Some were served in the community, while others were forgotten.[11] The federal government previously had entered the mental health field with the passage of the "Mental Retardation Facilities and Community Mental Health Centers Construction Act" in 1963.[12] With this federal money, augmented by local resources, almost 800 centers were established throughout the nation in the next decades. However, it soon became apparent that these facilities did not obviate the need for inpatient state mental health facilities. In addition, the CMHCs found a new population to serve and rarely confronted the problems of the chronically mentally ill until quite recently.[13]

More changes were to come. In 1977 there was a newfound focus on the rights of the mentally ill, encouraged by the President's Commission on Mental Health, chaired by Rosalyn Carter. The commission panel on legal and ethical issues indicated that "even the best intentioned efforts to deliver services to mentally handicapped persons have historically resulted in well-documented circumstances of exploitation and abuse" and emphasized "the importance of building a strong patients' rights and consumers' perspective into any reform in the services system." An advocacy system was endorsed which would be "able to respond to the legal needs of mentally disabled persons and [be] independent of providers of mental health and developmental disability services." The advocacy system for the mentally ill did not come into being as a federal program until 1986. Each state now has a protection and advocacy system program devoted to providing services for the mentally ill.[14]

The 1980s saw a new push for reform in the mental health system. There had been a tendency to focus solely on dangerousness as the basis of commitment. Standards had often been stretched to include those individuals who were unable to care for themselves in the community. During this decade many jurisdictions, including Texas, have added criteria specifically addressed to this population. The Hogg Foundation helped underwrite the activities of the Mental Health Code Task Force in 1982–1983 which was chaired with considerable skill and acumen by the late Helen Farabee. The Texas statute was overhauled. Indefinite commitments

were abolished. Criteria were specified with more detail, and the role of the attorney was articulated for the first time in any statute in the country.[15]

Faced with judicial and legislative decisions which focus on the individual's autonomy, some families have felt frustrated in their good faith efforts to help their relatives receive treatment. Even when they sought commitment as a last resort, they sometimes found themselves excluded from the process. The chronically mentally ill often fell through the cracks and received little if anything in the way of services on an ongoing basis. This bleak situation left many families unable and unprepared to cope with a mentally ill relative who required some services. This question will be addressed in detail later in the chapter.

While the pendulum was swinging dramatically in the direction of a focus on the rights of the individual who might require mental health services, there was a countermovement taking effect concerning minors. Juveniles had been among the beneficiaries of constitutional litigation concerning detention and confinement. In 1967 the United States Supreme Court held that even though juvenile delinquency proceedings were civil as opposed to criminal in nature, the due process clause still applied to these hearings. Juveniles would be entitled to representation by counsel and be provided free counsel if indigent. In addition, rights normally afforded adults in criminal proceedings, such as the requirement that the state prove each element of the offense beyond a reasonable doubt, would be applicable to juveniles, with the exception of a jury trial.[16] Compliance with these decisions was spotty nationwide. In Texas a case which began as one addressing improper adjudication procedures expanded to include the operation of the entire juvenile justice system. Similar efforts took place nationwide.[17]

The mid-1970s probably represented the high-water mark concerning the rights of juveniles. At the end of the decade a series of cases was brought concerning the way in which minors were being admitted to mental health facilities. The most common method was for the parent or conservator to "volunteer" the admission of the minor. This so-called voluntary admission was subject to no review. Courts began to strike down these procedures as violative of the minor's constitutional rights. Reasoning by analogy from the Supreme Court decisions concerning juvenile delinquency proceedings, lower courts held that civil commitment proceedings for minors must approximate those provided for adults. The Supreme Court already had indicated that states could not grant parents veto power over a decision by a minor to have an abortion.[18]

However, in 1979 the United States Supreme Court refused to apply this logic to the admission of minors to mental health facilities. The court majority focused on the family as a unit and concluded that there was no reason to upset the traditional presumption concerning the "natural bonds

of affection" between parents and children. The state should only interfere when it is clear that those bonds have been broken. Children were entitled to due process protections, but the extent of those protections was circumscribed and bordered on meaningless. Someone other than the physician arranging admission to the mental health facility had to approve of the decision. In addition, some form of periodic review by the facility would be necessary. The court concluded that adversarial hearings would be inappropriate; hospital staff could protect the interests of the minor. The majority chose not to require some type of legal advocacy, but abdicated completely in the area of juvenile admissions to psychiatric facilities. As long as the individual was a minor, the constitutional protections afforded by due process would be quite limited.[19]

When there is intrafamily conflict between the minor and his or her parents, the minor's interest is of no weight. In Texas the decision of the United States Supreme Court had little impact since the then-existing Texas Mental Health Code required hearings for minors. The Department of Mental Health and Mental Retardation unsuccessfully sought an attorney general's ruling that the Supreme Court's decision would override the protections afforded by the state statute.[20] However, in 1983 the legislature did change the procedure for voluntary admissions. Under the Code today parents may admit their children into a mental health facility without the child's consent when the individual is below the age of 16. However, once the minor becomes 16, he or she is to be treated as an adult and may not be admitted simply upon the signature of the parent. This also means that a 16-year-old may voluntarily enter a mental hospital without the parent's consent.[21]

Even though the Supreme Court treated nonparental conservators identically with parents, the Texas legislature chose not to. It recognized that the bond between a parent and child is different from the relationshp between the state and children under its care. Therefore, in situations where a person or an agency has been appointed guardian or managing conservator on behalf of the state, voluntary admission of a minor is prohibited unless the individual proposed patient consents to the admission. In order to obtain services, the individual serving as managing conservator or the appropriate agency may apply for court-ordered mental health services, and the statutory criteria for commitment used for adults must be met.[22]

The consequences of the Supreme Court decision have been significant. There has been tremendous growth in the area of admission of minors to mental health facilities. With the decision authorizing admission by parents of protesting minors to mental health facilities, there has been a confluence of other factors which have resulted in a dramatic increase in admissions. Private insurance is often available to cover inpatient services

for minors. (This usually is not the case for the family member who is unemployed and an adult.) The federal government through a variety of incentives has encouraged states to stop confining so-called status offenders in juvenile institutions. These are individuals who are declared to be "children in need of supervision" or some other similar category; the mental hospital is now an alternative placement. It is relatively easy to obtain the admission of a minor to a mental health facility. Third-party payment is often limited for outpatient care but more generous for inpatient care, at least of a limited duration. According to one study, between 1980 and 1984 admissions of adolescents to *private* psychiatric hospitals rose from 10,764 to 48,375. During the same period the number of adolescents in the general population declined. Furthermore, the number of adolescent admissions to public mental health facilities decreased during the same period.[23]

Obviously, some admissions are warranted. However, the dramatic increase in private psychiatric facilities has led some to question the need for all this inpatient care. The Mental Health Clinic of The University of Texas School of Law represented some juveniles prior to and after the change in Texas law in 1983. The limited anecdotal experience was that when adolescents protested their admission to a mental health facility, particularly a private facility, commitment proceedings did not take place. Instead, the individual adolescent would be discharged at the end of the period of protective custody—14 days. This "safety valve" of an outside person looking at the situation, an advocate for the youth's position, no longer exists.[24]

A dramatic shift takes place once an individual reaches age 16 in Texas or 18 in certain other parts of the country. Now, serious intrafamily conflict concerning the need for mental health services no longer can be resolved by the act of voluntarily admitting the minor to the mental health facility. In order to force admission, involvement with the judicial system is necessary. Going to court is an involved procedure and involves numerous players who are not members of the family. While mental health proceedings are confidential, there still will be strangers looking at a family situation. No matter how sympathetic those individuals might be, it is still embarrassing to many to expose family difficulties to outsiders. Furthermore, the family loses control of the situation as various persons perform their specialized roles which might be adverse to some family members' interests.[25]

If the service provider, the consumer of services, and the family could all agree, the delivery system would be working well. However, conflict is common. An individual might not wish to take medication and might be behaving in a manner which upsets other family members. If the person already is a consumer of services, the family members often first will seek

help at the level of the service provider. Depending on the seriousness of the situation, the service provider might or might not take action. Another possibility, especially when an assault or some type of property damage is involved, is an appeal to local law enforcement officials. This means that family members will be telling their situation to an outsider who in turn will be making some judgment about whether state intervention would be appropriate. This is not a pleasant situation for anyone. If one member of the family is taken into custody and brought to a mental health facility, the saga has only begun. First, there will be an evaluation to determine whether involuntary commitment is appropriate. If not, the individual will be released immediately.[26]

Even upon admission, there is no quick fix. Rather, a more elaborate evaluation will take place, and if necessary an application will be filed for an order of protective custody as well as an application for court-ordered mental health services accompanied by a physician's statement indicating that immediate restraint is necessary pending the hearing. As an alternative, the family member could file with the court the application for court-ordered mental health services and the application for an order for protective custody, once again accompanied by a physician's evaluation.[27] This could be a frustrating option, because the family member might be unwilling to appear at a physician's office. Therefore, the police route is often the method chosen.

Family members who have chosen to seek court-ordered mental health services for a loved one often feel abused by the process. The focus of attention is on the proposed patient; often, it appears to family members that they are lost in the shuffle of paper. The county or district attorney represents the state in these proceedings.[28] Even though a family member might have filed the application and/or paid the filing fee, it is the individual from the county or district attorney's office who will decide if the case actually goes forward. While they will sometimes seek information from the family members, most often they rely almost exclusively on the information provided by the social worker and psychiatrist at the mental health facility. A hearing concerning an order of protective custody is required within 72 hours.[29] Often, family members might not be aware that this preliminary hearing is even taking place. Family members sometimes wonder who is representing their interests since at first blush it might appear that the attorney for the state is really representing the service provider.

In addition, suddenly entering the picture is an attorney for the proposed patient. This individual might contact family members, and family members will attempt to persuade the attorney of the correctness of their actions in seeking or supporting involuntary hospitalization. However, that attorney has only one client, the proposed patient—not the proposed

patient's family. At one time, as noted earlier, family members could waive all manner of rights of the proposed patient. Similarly, attorneys could do likewise and would often consult with the next of kin to accomplish this task. Those laws have been superseded, and if they still existed such statutes would be struck down as unconstitutional. The proposed patient is an autonomous individual and instructs the attorney as any client would in consultation with counsel. The Mental Health Code is explicit concerning the obligation of the attorney.

> The attorney may advise the person concerning the wisdom of agreeing to or resisting efforts to provide mental health services. Whether or not to resist such efforts, however, is a decision to be made by the person. If the person expresses a desire to avoid court-ordered mental health services, the attorney has the duty to use all reasonable efforts within the bounds of law to advocate the person's right to avoid court-ordered mental health services, without regard to the attorney's personal view.[30]

Family members find this provision difficult to comprehend. They will ask, "Don't you think my relative needs to be hospitalized?" The attorney will not answer the question but will change the subject since communications with the client are confidential unless the individual client releases the attorney from the obligation of confidentiality. The family often feels beleaguered.

There are many dispositions to mental health cases besides having a formal hearing. A proposed patient can agree to commitment. Or, some type of compromise situation might be worked out such as agreement to court-ordered outpatient services. Even if the family members were the applicants for the commitment proceedings and even if the individual proposed patient had resided with the family prior to admission to the state hospital, it is still the individual proposed patient who makes the decision on whether or not to agree to some form of outpatient treatment. Sometimes, the family might not even know of the agreement until it has already been approved by the court and entered as the judgment in the case.

For example, in situations where the family has persuaded the proposed patient to enter a mental health facility voluntarily, the family may not be involved in discharge planning. Once again, it is a matter of autonomy of the individual. It is the proposed patient who must agree to involve the family in treatment and future planning. It is inappropriate for mental health professionals to discuss matters with the family without consent of the individual. To ensure that family members are involved to the maximum extent possible, the Texas legislature added a new provision in 1987 which requires staff to notify all patients of the fact that the patients may grant permission to the staff to inform relatives of scheduled release dates. Once permission is obtained, staff is obligated to attempt to notify the relatives.[31] Thus, family members have no veto power concerning what happens to their relative. The hospital may discharge the individual without their agreement.

A hearing is a traumatic event for many family members because it means that they will be telling their story to outsiders and be subject to cross-examination about the details. It can also be a frustrating experience. The rules of evidence, with some exceptions, require that an individual testify based on personal knowledge. Sometimes a family member will begin to mention something that a neighbor reported about the proposed patient. That statement will be inadmissible if objected to by the attorney for the proposed patient unless the neighbor is present to testify. The issue at stake at these hearings is the liberty of the relative. Individuals might commiserate with the family members about the situation; however, the family is not the focus of the proceeding. When the hearing is over, and the judge has ruled, the family members often have mixed feelings. If the proposed patient is committed, it is often heart-wrenching to know that you helped commit a close relative. Because of these mixed emotions, sometimes family members decline to attend hearings or are unwilling to tell personal stories which are directly relevant to the issue of commitment.

When the court declines to commit an individual, the family is left with a difficult situation. Do they readmit this person back into their household, or do they separate themselves from the individual? It is not an easy time for the family. Even after an individual is committed, the family members often learn that the duration of confinement might well be brief. The average commitment period is not long, and the family will once again have to confront the fact that their relative will no longer be hospitalized. Especially for chronic schizophrenics, the mental health facility is often a revolving door. In the facility the individual takes medication and seems to understand the need to take medication. Once discharged, the individual feels better and decides to no longer take the medication. After a time, decompensation may occur and hospitalization might once again be necessary in a matter of months. The hospital acted appropriately in discharging the individual because at the time of discharge the person no longer met the statutory criteria for involuntary hospitalization.[32] However, this does not make life any easier for the family.

As I noted earlier, commitment to a mental health facility once meant that an individual was incompetent to manage one's own affairs. This is no longer the case. The Texas Mental Health Code provision is typical.

> Court-ordered mental health services or emergency detention under this code or receipt of voluntary mental health services shall not constitute a determination or adjudication of mental incompetency and shall not abridge the person's rights as a citizen or the person's property rights or legal capacity. Mental competency is presumed in the absence of a contrary judicial determination under the provisions of the Texas Probate Code.[33]

This means the family member who is mentally ill and needs services, even court-ordered involuntary services, is still legally capable of managing

property or making individual decisions about his or her life. Decisions concerning competency are separate from decisions concerning hospitalization, although the same court usually is involved. Guardianship proceedings are time-consuming and expensive, and it will be a judicial determination as to whether or not a guardian is needed. As with other areas of the law concerning the mentally ill, the standards and practices concerning guardianships have been strengthened in recent years, and the focus once again is on the individual and not the family.[34] Similarly, the Social Security Administration which formerly appointed family members as representative payees with very little evidence concerning competency, now has a more elaborate investigatory process.[35]

I have presented a rather pessimistic story. In the case of minors, not enough respect is given to the wishes of the individual receiving mental health services. With regard to the adult, the mental health system often seems to ignore concerned family members. It is unlikely that the basic structure of the system will change anytime soon. Adolescents do not have many advocacy groups lobbying state legislatures, and I do not foresee any groundswell of public opinion to alter the process for minors. There has been some action on the federal level in terms of congressional hearings,[36] but this is not an area in which the federal government is likely to mandate any procedure for the states.

For adults, however, there is much that can be done and which currently is being done. Legislation is not the answer. At this point, most of the legal requirements associated with the civil commitment process are the result of widely held views concerning which procedures are constitutionally mandated. The current focus of litigation has tended to be on the right to refuse treatment and not on issues of admission.[37]

With an increase in outpatient services, and with better coordination of services between the inpatient and outpatient facilities, there is some hope that many individuals can be stabilized and then released into the community. The number of group home facilities or other housing alternatives is far less than the demand, and board and care facilities or rest homes vary widely in quality. Improved support services appear to be one approach which can ameliorate the sense of frustration, isolation, and ineptness faced by many family members. There are groups such as the Siblings and Adult Children Network of the National Alliance for the Mentally Ill which put individuals in similar situations in contact with one another.[38] Better community services obviously are part of any solution, and this volume describes new and exciting programs. Unfortunately, there is no panacea. Conflict will continue to exist, and the conflict will impair the ability to deliver services. The answer is a better level of services, not a futile attempt to restrict the autonomy and rights of the individual who is mentally ill.

ENDNOTES

1. For general background, see Goffman, E., *Asylums* (1961); Grob, G., *Mental Illness and American Society, 1875–1940* (1983); and Rothman, D., *The Discovery of the Asylum* (1971).

2. *New York Times*, Aug. 5, 1988, at 1, 8, 22.

3. For an early review of civil commitment law, see "Developments in the Law—Civil Commitment of the Mentally Ill," 87 *Harv. L. Rev.* 1190 (1974).

4. Cohen, F., "The Function of the Attorney and the Commitment of the Mentally Ill," 44 *Tex. L. Rev.* 424 (1966).

5. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

6. For a review of the early cases, see "Developments," *supra*.

7. *Addington v. Texas*, 441 U.S. 418 (1979).

8. For a summary of the litigation, see *R.A.J. v. Miller*, 590 F.Supp. 1310 (N.D.Tex. 1984).

9. For a detailed review of Texas legislative changes, see Churgin, M., *An Analysis of the Texas Mental Health Code* (1988).

10. For a review of the changing situation from the perspective of a leading psychiatrist, see Stone, A., *Mental Health and Law: A System in Transition* (1975).

11. For a summary by a social scientist of the phenomenon of deinstitutionalization, see Lerman, P., *Deinstitutionalization: A Cross-Problem Analysis* (1981).

12. Pub. L. No 88–164.

13. For an analysis and new approach to the problem, see the chapter by Martin Cohen in this volume; see also Shore, M., & Gudeman, J., eds., *Serving the Chronically Mentally Ill in an Urban Setting* (1988).

14. The Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Pub. L. No. 99–319) was reauthorized and strengthened in 1988 (Pub. L. No. 100–509).

15. See Churgin, *Analysis*, *supra*. The American Bar Foundation has prepared an exhaustive national survey of legislation in the mental health field, Brakel, S., et al., *The Mentally Disabled and the Law* (1985).

16. Compare *In re Gault*, 387 U.S. 1 (1967), with *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

17. Churgin, M., "A Comparison of Mandated Change in Texas: The Federal District Court and the Legislature," in *Neither Angels Nor Thieves: Studies in Deinstitutionalization of Status Offenders* (Handler, J., & Zatz, J., eds.) (1982).

18. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976).

19. *Parham v. J.R.*, 442 U.S. 584 (1979), and *Secretary of Public Welfare v. Institutionalized Juveniles*, 442 U.S. 640 (1979).

20. Attorney General Opinion MW-180 (1980).

21. §23, Texas Mental Health Code. See Churgin, *Analysis*, *supra*.

22. *Id.*

23. I am indebted to Lois A. Weithorn for her insightful presentation of this new phenomenon in juvenile admissions to mental health facilities. Note, "Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates," 40 *Stanford L. Rev.* 773 (1988).

24. I direct the Mental Health Clinic. Once again, based on anecdotal evidence, individuals now remain in facilities for a longer period of time.

25. My description of the process is based on my experiences in Texas. Since 1975 I have supervised students enrolled in a law school clinical program in the representation of individuals at civil commitment proceedings.

26. §26, Texas Mental Health Code.

27. §§36, 32, Texas Mental Health Code.

28. §13, Texas Mental Health Code.

29. §38, Texas Mental Health Code.

30. §45, Texas Mental Health Code.

31. §§25(b), 81(c), Texas Mental Health Code.

32. §71, Texas Mental Health Code.

33. §83, Texas Mental Health Code.

34. For a survey of these laws, see Brakel, *Mentally Disabled*, *supra*.

35. 20 C.F.R. §404.2001 (1988).

36. "Emerging Trends in Mental Health Care for Adolescents," *Hearings before the House Select Committee on Children, Youth, and Families*, 99th Cong., 1st Sess. (1985).

37. Arlene Kanter has presented a survey of the current state of the law in the field in her chapter in this volume.

38. Moorman, M., "A Sister's Need," *New York Times Magazine*, Sep. 11, 1988, §6, at 44; Goldstein, M., ed., *New Developments in Interventions with Families of Schizophrenics* (1981).

# The Future of Community Care for Persons with Chronic Mental Illness

Dennis R. Jones, *Texas Department of Mental Health and Mental Retardation*

As one of this state's mental health commissioners and as the current president of our National Association, I have had the chance to watch many commissioners come and go. The current job life for a mental health commissioner is now less than two years. At a recent orientation session (which we do every six months), we had *23* new commissioners. Our association has set up special training programs with the singular intent of trying to bolster the skill levels and at times the morale levels of this group. There are undoubtedly many reasons for this rapid turnover in top leadership positions: most commissioners serve at the pleasure of elected officials (usually the governor); advocacy issues are not only volatile but often divisive; limited resources exist in the face of increased expectations; there is ever-increasing complexity in federal programs, financing schemes, and conflicting policies and regulations—and the list could go on. The point of mentioning this is not to draw sympathy for any commissioner; we've all gotten into this voluntarily. It is rather to say that amid the swirl of activity and issues on any commissioner's platter, there is one overriding service issue against which all mental health commissioners will be judged: how well are we caring for the seriously mentally ill? If we are not doing the job well, then what are we doing to improve that system of care?

As this commissioner attempts to face that challenge here in Texas, let me share with you some of my beginning beliefs and biases.

We need new and more positive ways in which to describe what we are about. We have developed a whole set of code words in this field, e.g., deinstitutionalization and least restrictive environment.

These words tend to take on a life of their own, conjuring up all sorts of good or bad images, depending upon your point of view. Imprecise words, as Leona Bachrach has pointed out, can have the effect of letting us read into them whatever definition fits our own experiences or purposes. Yet beyond the imprecision and cloudy thinking that such words perpetuate, I don't like them because they sound like double negatives—deinstitutionalization, least restrictive environment. What do those mean to the general public? Probably not much. The point is, we need a positive image of what we are about—both for ourselves and for the public at large.

That description needs to do more than simply describe (or undescribe) settings. As we know, the history of care for the seriously mentally ill is a history of magical thinking: if only we would change the locus of care, people would get better—from the stress of urban areas to rural asylums and from the overcrowded institutions to community living. What we have painfully learned is that the same percentage of the population that didn't fare well in one setting has not fared well in the other. It is not the setting alone that effects more positive outcomes; it is more importantly what happens in whatever settings in which this most difficult population resides.

For me, the need is to provide a system of psychosocial rehabilitation that cuts across all treatment settings. The "age of rehabilitation," into which I hope we are moving, meets the test of being a positive descriptor for ourselves, our clients, and their families. If we must argue, let's not argue simply over the locus of care; let's argue about who, how, and where we can do the best job of providing the kind of incremental, consistent, and caring services that mark good psychosocial programs. It has been said that deinstitutionalization was intended to put *freedom into life*; rehabilitation is intended to put *life into freedom*.

As we embrace the concepts of a comprehensive system of care, including psychosocial rehabilitation, we should not be hesitant (as a matter of public policy) to embrace the array of needs that our most seriously mentally ill bring. Since 1981 state departments of mental health have become more clearly the focal point for developing public mental health policy in this country. Concurrently, more attention—and criticism—has come regarding the care, or lack thereof, for the seriously mentally ill. I find it interesting, in that context, to watch the evolution of mental health policy. All states recognize the need for a comprehensive array of community-based services: case management, residential, vocational, and other medical and support services. Yet many states have been reluctant to list residential and vocational services, for example, on the mental health ledger—for fear that the mental health system will bear the full financial and legal responsibility.

My belief is that we must take on and embrace the array of services needed for the seriously mentally ill. If we don't, who will? For me there is a difference in taking on the clear leadership role and taking on the full fiscal and service responsibility. It has been my experience that the more we aggressively target services, the more leadership we provide, the more other entitlement providers are willing and able to participate. In the same way that case managers access and coordinate both specialized and generic services, so we at a policy level need to say, "We want to take on leadership responsibility for this population, but we need your help."

We need to develop new and revitalized partnerships. I recently read the report of the League of Women Voters entitled "Services for the Seriously Mentally Ill in Texas." It struck me afresh: there are many groups outside of our traditional circles who want to help. The family movement has taught us many things, one of which is not to underestimate the political force that such a movement can bring. It behooves us as mental health leaders to join forces with an expanded network of professional groups, religious groups, business, and industry—with a clear and concise message: Please join us in the fray. One of the really pleasant surprises I have had in Texas is how willing so many people and groups are to help. We need to find ways to harness that energy as we head into the next legislative session.

We also need to develop stronger ties to our universities. The public system shares with the university system the common overall mission of services, teaching, and research. While the emphases vary, it seems to me that there are real congruent goals. We need to develop much stronger university ties in planning, training, service delivery, and research. One of the tasks our new medical director will take on when hired is to help us build those linkages. We are looking already at some very exciting possibilities involving residency programs, a new research unit, and a new university-based inpatient unit.

We need to constantly revisit the question of accountability. I struggle with the question of accountability as much as any, perhaps because it seems like such a simple and a central question for any administrator. However, as we all know, that accountability issue is multifaceted. Accountability to whom and for what? The other major dilemma, which the Robert Wood Johnson (RWJ) Foundation proposals and Dane County have addressed head-on, is how do we bring authority and accountability together in delivering services to the seriously mentally ill. The myriad funding streams, each with its own unique doors of access, make resource coordination alone a formidable task. The RWJ model programs—with one right here in Austin—give us an opportunity to evaluate new models of care and new models of resource coordination. We need to do similarly at a state level. We need to develop strong interagency models, targeted toward high risk groups and not toward maintaining our agency barriers. The model I envision is one with a lead agency but one in which all agencies agree to pool ideas and resources. That interagency group, in order to function, must have clearly vested authority. It seems to me that such a model is what we need as we attempt to develop a coherent system of care. The state needs to do first what we are asking local communities to do.

Other aspects of accountability are equally troubling, though. One of the reasons it is so important for me to visit actual services, clients, and direct

care staff is that I get a chance to move beyond what should be, or what I think is, to what actually is. I used to be more of a "big picture" manager—goals and objectives, strategic plans, and all of the other things I thought I knew. I hope I am still a big picture manager, but I have come increasingly to see the importance of being a "snapshot" manager. I like to take snapshots of the system—at the client level. Some of those snapshots are pleasant ones, others very distressing.

The question I ask myself is how can we increase our accountability to those we serve, both the seriously mentally ill and their families. The beginning points are to listen to and involve our consumers at all levels of services planning, advisory boards, and so forth. That is an extremely important first step. There are some systemic "fixits" that we've talked about: fixed organizational accountability, clearer tracking of both client and dollars, and revisiting the concepts of core services. We as a system need to look carefully at all of those issues over the next couple of years. I hope this Commission can help us both conceptualize and implement. But let us ask this question as we proceed: If our clients and (and/or their families and/or case managers) were buying services from us, what would our service system look like? Our in-home and family support program is developed with the following premises: fixed dollar caps per year, a range of services permitted, and client control over the mix of services purchased. We will be watching this model carefully. The fundamental notion is that our system needs to be driven by the uniquely expressed needs of entitled persons; those persons (or their surrogates) need to have some say over what they receive. Control over resources (even when limited) begins to meet the test of empowerment, our newest buzzword. Consumer-run, consumer-owned models become one way of meeting that test.

We need to expand our knowledge base. A colleague in a totally different field once commented, "For as little as you all know about what you do and why you do it, I'm surprised you're not more humble." In addition to a good dose of humility, we need as a state and as a national mental health system to expand our knowledge base.

I have had the opportunity as a member of the National Mental Health Advisory Council to be involved in the development of the National Plan for Schizophrenia Research and the concurrent report to Congress on the Decade of the Brain. These two documents, one focused on clinical research and the other on basic research, form an incredibly exciting opportunity for new understandings of major mental illnesses. The major mental health advocacy groups are coalescing to develop a congressional strategy for funding support. Currently, less than one-third of one percent of what is spent on mental health treatment is spent on research. As a part of the NIMH initiative, there are some exciting possibilities for Texas:

- Opportunities for new centers on schizophrenia research;
- Opportunities for research centers on the financing and delivery of mental health services;
- Opportunities for a new public academic liaison (PAL) grant designed to encourage clinical research programs in the public sector. We have the patients; universities have the research expertise.

Clearly, additional research dollars are needed for clinical research, basic research, and services research. To make that happen, we need what new ADAMHA administrator Fred Goodwin calls a "psychology of hope." He makes the point that research dollars began to flow in the health sciences (heart and lung research) when the public and the Congress began to be hopeful about research breakthroughs. We are at a point now, despite our limited knowledge, to be hopeful. The next ten years should bring major research advances in genetics, immunology, brain structure and chemistry, psychopharmacology, psychosocial programs, and other related areas. These scientific advances will have major impacts on our service systems.

In sum, I hope I have communicated the kinds of themes I trust will mark our years ahead as we continue to shape the system:

- hands-on;
- client-driven, accountable, synergistic;
- knowledge-based;
- hopeful and caring.

# Community Care of the Chronically Mentally Ill: Summary Comments

David Mechanic, *Rutgers University, Institute for Health, Health Care Policy, and Aging Research*

It is a pleasure to have the opportunity to make some summary comments on a stimulating meeting so rich in substance. I have had the privilege of watching the establishment of the Commission on Community Care of the Mentally Ill from its initiation as a member of the National Advisory Council of the Hogg Foundation. The Foundation is to be commended for its efforts to put the issue of severe mental illness high on its agenda, and particularly to be commended are those who have been working hard to set the stage for an improved system of care in Texas. In addition to the members of the Commission and Ira Iscoe, the Chair of the Commission, Wayne Holtzman and Chuck Bonjean deserve special recognition for contributing their creativity, energies, and support to ensuring a thorough and useful process.

Your presence here in the past two days and the commitment of the Hogg Foundation to see this process through are essential steps. The severely mentally ill need an involved and articulate constituency if services are to be improved significantly. The formulation of health policy is fundamentally a political process depending importantly on what Bardach (1972) has called "the skill factor." Meetings of this kind allow for the sharing of information and the development of a coherent and unified agenda. Mental health advocates must learn to compete with many other disease constituencies that have developed their political and public relations skills over decades.

Advocates for the mentally ill often not only lack the necessary skills but compete with one another in an unconstructive way that can greatly diminish public support. In some communities these competing groups are now making efforts to come together to develop a unified agenda that emphasizes their common concerns and downplays their differences and conflicts (Cromwell, Howe, & O'Rear, 1988). This is an essential strategy if mental health advocates are to get their fair share of health and social service resources. The unmet needs of the mentally ill are extraordinarily large, and gaining public sympathies is no trivial matter. It is sad, indeed, when the mental health arena loses support because the advocates fail to "get their act together." I have faith that through your Commission activities and your broad-based participation in defining issues and agendas you can avoid the acrimony that too frequently occurs.

Developing appropriate systems of care for the seriously mentally ill involves two levels of activity: developing the knowledge and technological base and defining the optimal content of care at any point in time and developing the financial, organizational, and political structures that make implementation of what we know possible. In the first instance, we must never forget how little we truly know about the causes of mental illness and its treatment and prevention (Mechanic, 1989). Commissioner Jones made the case for needed research last night, and in the process of doing what we now can we should not neglect future progress.

The concept of technology refers to much more than to hardware. It applies to a process of organizing inputs—people, machines, materials, or whatever—in order to achieve desired results. In this sense, the care of the seriously mentally ill involves a variety of technologies that have been proved to be effective in diminishing pain and disability and in enhancing the quality of patients' and families' lives. We, of course, have medications of enormous utility when carefully prescribed and monitored. We have innovative community programs such as PACT described by Stein, Fairweather Lodges, and clubs based on the Horizon House model, technologies that have been demonstrated to be effective in controlled trials as well as other studies. There is much still to learn, but there is much we know that can be implemented now.

Implementation must occur in a wide range of settings, with different patient populations and varying subcultural groups. It must be sensitive to varying social and political structures of communities and their special economic and professional problems. The capacity for implementation depends substantially on the organizational and managerial structures that allow care to be financed appropriately and to be directed to defined priority groups.

Consider case management as an example. Case management has become the popular solution to almost every problem, and the concept is used to characterize providers and care arrangements varying so widely as to have no coherent meaning at all. Even in the narrow definitions included in Medicaid experiments in varying states, there is no consistency or agreement about the concept (Spitz, 1987). Case managers may be paraprofessionals or well-trained therapists; they may command significant treatment resources or none at all; they may or may not have influence within the organizational systems within which they work or with providers; and they may suffer conflict between their responsibilities to clients and to the organizations that employ them.

In terms of implementation, it is especially important to differentiate case management as something a mental health worker does from case management as a program or systems responsibility. Case management must adhere to the principles that Len Stein described in his opening

lecture. There must be a fixed point of responsibility for every patient, and the system of care must be held accountable for fulfilling that responsibility. Such responsibility is longitudinal with no arbitrary time limits, and thus must transcend the job tenure of any particular case manager, therapist, or other provider. Case management, properly seen, is in its essence an organizational function, and one that must be the core that ties programmatic elements together.

There has been a considerable consensus at this meeting about a number of key points. There is wide recognition that appropriate care for the severely mentally ill requires longitudinal responsibility and clearly defined accountability. It is especially important to garner all of the resources possible from varying programs and payors, including Medicaid, and to guide the allocation of these resources in cost-effective ways. We have learned of the need to be especially sensitive to people commonly lost in the system—patients with dual diagnoses, the homeless mentally ill, and resistent young patients who refuse to come to terms with their illnesses. Appropriate care requires a network of medical, psychiatric, psychosocial, and rehabilitative services sensitive to the individualized needs of each patient, and effective organization of services requires the ability to coordinate programs of local, state, and federal governments in different categorical sectors including the social services, housing, disability insurance, and rehabilitation.

Even with an active and strong constituency we can anticipate in Texas, as elsewhere, that services for the seriously mentally ill will be seriously underfinanced. This reality makes it even more urgent that funding be consolidated, that priorities be focused, and that the service system be well managed. The best functioning state systems are not necessarily the best financed, but severe underfinancing can cripple even the best structures and management.

Two basic strategies are being examined to improve the financial and managerial approach to care for the severely mentally ill dependent on public support. One strategy, now being tested in nine of the nation's largest cities, involves efforts to develop local mental health authorities that have sufficient control over resources and political and professional legitimacy to manage care in a cost-effective way. Sponsored jointly by the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development (RWJ-HUD), this demonstration seeks to integrate the development of appropriate housing as part of a comprehensive approach to the needs of the most severely ill (Aiken, Somers, & Shore, 1986). Austin–Travis County is one of the funded demonstration sites, and it is being watched with great interest. The demonstration allows for a variety of approaches to organizing and planning services, and through these experiences and their evaluation we hope to learn some useful lessons.

On the financial side, there is growing interest in funding strategies that provide incentives for well-managed community care. In particular, a number of localities are focusing on capitation as a way of bringing services to severely ill but poorly served patient populations (Lehman, 1987). Early efforts at mental health capitation were based on identifying patients with extensive hospital use who could be relocated in the community if adequate services were available. Thus a fixed capitation was seen as a way of reducing inpatient populations and allowing dollars to follow the patient as patients moved from the hospital to community living. Providers were expected to provide all necessary defined services for specific patients for a preestablished stipend, and thus were given a strong incentive to manage resources carefully since they would be at risk financially if their expenditures were higher than the capitation payments.

Captition as a strategy is viewed as having additional important potentials (Mechanic & Aiken, forthcoming). By tying payment specifically to the care of particularly difficult patients, mental health authorities could redirect attention to patients who are often neglected in the community. If sufficient numbers of patients are capitated, aggregate capitation payments provide a resource base for hiring new professionals and developing new services. Perhaps, most important, the focus of financial risk and responsibility induces the provider to consider carefully treatment trade-offs and to avoid unnecessary inpatient care.

Despite its intriguing possibilities, implementation faces some significant barriers. Capitated care may provide incentives for undertreatment, and it must be accompanied by good information and quality assurance systems. Organizing such complex systems requires considerable expertise, and there is much uncertainty in defining risk and appropriately setting capitation rates. Complex governmental regulations also make it difficult to consolidate some of the funding streams that are important to the severely mentally ill. In short, we still have much to learn in this area. The information from demonstrations now in place should be very helpful in future planning.

Lack of innovation has never been a problem in mental health services. There is an extraordinary range of innovative approaches—such as the PACT model (Stein & Test, 1985) and the Fairweather Lodges (Fairweather, Sanders, Maynard, Cressler, & Bleck, 1969) to note just two—that have been carefully evaluated and found to be effective. The problem is really implementation and the difficulty of transferring models that work to new contexts. There are many barriers to implementation; one of the major impediments is the lack of fit between professional training programs and the personnel needs of an effective system of community care. Training in all the key mental health professions—psychiatry, psychology, social work, and psychiatric nursing—is too oriented to

individualized psychotherapy and fee-for-service practice. Most professionals practice as they have been taught, and few training programs provide the experience in innovative care models that will make future professionals receptive to community care models. This is a necessary requirement for future progress, and I hope our universities will be responsible to the challenge. I don't want to oversimplify issues. The directions professionals choose are shaped by economic rewards, career opportunities, and prestige. If we cannot provide decent salaries, reasonable career pathways, and a sense of respect for those who provide community care to the most seriously mentally ill, it is unlikely that we will progress.

Prevention is a major theme in mental health advocacy, and we have been urged at this meeting to give it greater emphasis. To the extent that we have the knowledge to prevent serious illness and can target those at risk, prevention is a desirable strategy. We have to be tough-minded about our priorities, however, and must examine very carefully what technologies we truly have available that can prevent serious mental illness. We have some reasonably good approaches to containing disability and improving the quality of life of chronic patients, but I am skeptical of our preventive capacities. Generally very broad preventive approaches are advocated on the assumption that at worst no harm will be done. However, even if the intervention for each person is inexpensive, the inability to target specifically those at risk requires a large target group (Russell, 1986). In the aggregate the preventive effort may be expensive and the results meager. Thus, prevention may be an ineffective way to use limited resources.

A major section of this meeting has focused on issues of civil commitment and the frustrations of families in dealing with the legal process. We all are aware of the tensions between two important values, civil liberties and providing resistant patients with needed and appropriate care. The tension is often most evident at the point the legal system intervenes, but the more basic problems are the deficiencies of appropriate models of community care and the unwillingness or inability of the community to provide the types of services that ably manage crisis situations. The legal process makes the conflicts in the community evident, but tinkering with the legal procedures cannot really solve the most troublesome issues.

Experience shows that simply changing legal procedures without modifying resource capacity leads to new difficulties. In the state of Washington, for example, the legislature modified the statutes to expand civil commitment criteria but did not provide funds for expanding hospital capacity. As a consequence, the expanded numbers of committed patients displaced voluntary patients who had equally important needs and may have been more able to benefit from treatment (Pierce, Durham, & Fisher,

1986). We have heard from the audience of similar types of problems in some parts of Texas that have made voluntary admissions almost impossible.

Often the issue is not the specific statutes, but rather how psychiatrists, judges, and lawyers choose to interpret the law and the extent to which they cooperate with one another. Many states now have outpatient commitment procedures, but both mental health professionals and judges seem reluctant to utilize these mechanisms. A careful study of outpatient commitment in the state of North Carolina found that these procedures worked well or poorly depending on the degree of cooperation and communication between the courts and the mental health system (Hiday & Scheid-Cook, 1986). More often than not, the difficulties are less in the legal process and more in the mind-sets of those who administer it. This relates to the larger issue of stigma, and the need to think more deeply about how we can reduce the stigma of mental illness that adds an additional burden for patients and their families. An adversary relationship between the courts and the mental health system adds to stigma. Communication and cooperation make it possible to deal with even the most difficult dilemmas.

This conference has been far-reaching and has covered a large range of topics. It is, however, worthwhile to comment very briefly on some areas that were not thoroughly discussed but deserve intensive attention by the Hogg Foundation commissioners. In my capacity as special consultant to the RWJ-HUD initiative on chronic mental illness in large cities, I have been impressed by the extent to which the lack of housing or housing deficiencies cripple mental health programs. Almost everywhere one visits, locating suitable housing is very high on the agenda of mental health personnel. We need to study housing needs and the best mix of housing options responsive to the heterogeneity of patients. Further we must explore new ways of developing suitable housing and innovative financing for housing development. One impressive consequence of the RWJ-HUD initiative was that it required the mental health people to come together with the housing authorities in large cities. In many of these cities these people had never met or even talked with each other before, and one could see mutual understanding and new relationships developing during site visits.

General medical care for chronic mental patients is another issue requiring focused attention. The severely mentally ill have many medical problems as well, and often receive poor care. Good primary medical care is essential for these patients as is coordination between their medical and psychiatric needs. Many physicians are frightened of these patients and give them only the most cursory attention. We need much better models that successfully integrate necessary medical care into the total treatment plan for the patient.

Other issues that deserve special attention include the following: innovative ways of capturing more Medicaid funds and other federal entitlements; developing or expanding alternatives for managing persons "at risk" by expanded guardianship arrangements; and preparing for the impact of the AIDS epidemic on mental health facilities and the mental health system. Each of these is a very major issue, but I do no more than mention them here.

In these summary comments, I have only touched on a few of the stimulating points explored at this meeting. I look forward to following with great interest the dedicated efforts of the Hogg Foundation mental health commissioners as they work toward developing a more effective and equitable system of care for the state of Texas.

As Chuck Bonjean noted when he introduced me, I occupy the René Dubos chair at Rutgers University. René Dubos was an eminent microbiologist who gave his attention to broad ecological and environmental factors in health. Shortly before his death he was asked why he entitled a column which he wrote for the *American Scholar* "The Despairing Optimist." Dubos responded that he had studied many of the problems that concerned him and understood the deep and formidable obstacles that had to be overcome and that sometimes led to despair. But everywhere he went, he said, he was profoundly impressed by the commitment and accomplishments possible when intelligent and concerned people focused their attention on important public issues. This made him an optimist. Certainly the problems we face in improving mental health services are difficult ones. But, like Dubos, I feel confident that when so many good and intelligent people like you devote your energies to understanding the issues and inducing social change it is inevitable that we will see significant progress in mental health services in Texas.

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Workshops on

- Technological and Innovative Advancements
- Implementation
- Collaboration
- Training

# Technological and Innovative Advancements

Pamela Diamond

## Introduction

The stated goal of the subcommittee on technological and innovative advancements for the Commission on Community Care of the Mentally Ill has been to identify those recent technological applications and psychosocial approaches that might be implemented at the state level in order to improve the care and treatment of the severely impaired mentally ill. A brief overview of the committee's progress to date on this mission focused on three different but interrelated areas which have been discussed at length by the committee: technological innovations, psychosocial programs, and manpower resources.

## Overview

### *Technological Innovations*

In telecommunications, one item of discussion has been the need for increased utilization of computer networks to connect facilities offering care to the mentally ill. The technology is currently available to allow all such facilities to have access to vital client information at the time when it is often most needed—when a client is admitted to a new facility. While this type of system is possible technically, there are many barriers to implementation. The questions of access, confidentiality, funding, and security have yet to be resolved.

Another aspect of technology seen as important to those serving the mentally ill is in the area of video technology, encompassing videotapes and satellite transmissions. Training, both of staff and consumers, has been suggested as one of the most important applications of this technology to the mental health field. Another possible application would be to use direct or satellite transmissions to allow two-way communication between psychiatrists and other mental health professionals at leading medical centers and admitting physicians at smaller, often geographically distant, hospitals. When these physicians are confronted with complex psychiatric cases, consultation would be immediate, and the consulting psychiatrists might even be able to interview the client directly, thus eliminating the difficulties often associated with the use of secondary information.

Although there have been many important discoveries in the field of biotechnology, the committee has not focused on these in detail. The committee strongly supports increased biobehavioral research funding from diverse sources: federal, private, and state.

*Psychosocial Programs*

A great deal of attention has been focused on the application of new technologies to the mental health field. At the same time, however, a great deal of concern exists about the improved use of existing technologies in client treatment. Some psychosocial programs are good examples of existing technologies that have empirical support but which are not yet widely implemented. One of the challenges to this committee is to identify the barriers to implementation of proven effective treatment modalities and suggest ways in which these barriers might be overcome.

*Manpower Resources*

Another area which has received interest is the improved use of manpower resources. In many instances, improvement in the use of existing manpower is accomplished through collaborative efforts such as the cross-training of peace officers as mental health technicians in city/county police departments. The deployment of staff to nontraditional settings may also lead to more efficient and effective use of staff. For example, mobile crisis teams may be much more effective in some localities than the more traditional office-based treatment approach.

Based on this summary of the subcommittee's concerns, the Task Group was asked to assist the committee by (1) commenting on the progress to date, (2) identifying problem areas in which new tools and techniques are needed, and (3) offering suggestions for the Committee's further consideration. The following report summarizes the Task Group's response to this charge.

Summarizing the Work of the Task Group

*Direct Service Issues*

A consistent theme throughout the discussions on direct provision of services to the mentally ill individual was the need to consider carefully the linguistic and cultural heterogeneity of the population of consumers in Texas. This heterogeneity presents a unique challenge to planners as they try to implement treatment approaches that have been developed in areas where the population is either more homogeneous than or culturally very different from the population in Texas.

*Model Programs*. Those model programs which have been shown to provide effective treatment need to be identified and carefully studied. Because such programs are quite varied in organization, cost, and location, they should be evaluated in terms of their specific strengths and weaknesses rather than globally. Different parts of cost-effective programs could then be extracted and put together in new ways in order to meet the needs of specific Texas communities and clients.

The identification of program elements which effectively serve the needs of specific groups is only the beginning of the process. New programs need to be carefully integrated into existing structures, with attention to including staff at all levels, as well as consumers, in the planning and implementation of these changes. The need for institutional sanctions for new programs is essential, as is the need for developing creative funding schemes. The best methods are not always the most expensive to implement, yet funding must be adequate if programs are to achieve stability.

*Jobs and Vocational Training*. Job training, placement, and vocational rehabilitation are all essential elements in the recovery of the mentally ill individual. Many of the chronically mentally ill have few or no job skills, having become ill early in their lives. Other have been ill for many years, and the skills they once possessed have become obsolete or have just been forgotten. Some have both skills and advanced degrees but are denied the opportunities to make use of them because of stigma or fear. This diversity must be considered in any vocationally oriented programming. Matching a client's job skills with meaningful vocational activities could avoid a situation such as placing a recovering mentally ill client with a college degree in a position of mopping floors when other, more appropriate, work can be made available. Also, training should develop skills which are marketable. For example, it does not do clients much good to be trained in the use of manual typewriters if most clerical job opportunities require knowledge of word processing.

Efforts should be made to work with both junior and senior colleges to develop appropriate training opportunities for the mentally ill. Collaboration with other organizations such as the Texas Rehabilitation Commission and the Small Business Administration is also necessary if training is to be varied and funded.

The Fairweather Lodge Program is an example of one program which attempts to bring together these essential elements. Within the Lodge Program there is both career planning and implementation. Although the Fairweather Lodge Programs usually focus on janitorial work, many levels of skill are required of the clients in the successful operation of this type of

business. Job coaches are used at all levels to provide support for those individuals just starting in the vocational rehabilitation process. This support system is seen as essential in the prevention of regression and deterioration at the times when the client is most vulnerable. When clients themselves become the job coaches, yet another area is provided in which they can develop their skills.

*Use of Volunteers*. The use of volunteers is quite desirable at all levels in the treatment and rehabilitation of the chronically mentally ill. Volunteer programs can be enhanced by the use of paid coordinators, providing adequate recognition for volunteer efforts, and recruiting volunteers from a wide variety of sources. Retired workers, professionals in the field of mental health, and consumers are all potential sources for this important work force.

*Traditional Counseling*. The importance of traditional counseling in the rehabilitation of the chronically mentally ill is also an issue. Counseling services are not as accessible as might be desired for this population. Although effective counseling has been shown to help improve coping skills, lead to better job performance, and reduce the client's reliance on medications, this population continues to be underserved. These services have been severely reduced by the public mental health system as the community mental health centers have struggled to provide other required services to this priority population on a limited budget. For example, one community mental health center has a waiting period of approximately one year to receive counseling services.

*Consumer Issues*. One of the most vital issues in the area of direct service is the role of the consumer in the mental health system. While consumers have often been socialized by the system to refrain from asking questions and to rely on the "good judgment" of the professionals involved in their care, many rebel against this ascribed passive role. Consumers have been found to be an untapped resource in the mental health system of care. They have firsthand knowledge of the difficulties involved in this system, and they can often, when in the recovery phase of their illness, provide valuable services to those clients who are in need of more intensive intervention. Consumers can provide cost-effective social support by serving as job coaches, providing valuable input into the planning of new services, and often acting as effective lobbyists with the legislature when new funds are solicited.

Increasingly, consumers are demanding to be recognized as human beings with strengths as well as weaknesses. They want to know the rationale behind their treatments, the side effects of their medications, and

the options which they have as consumers of health care. When in recovery, they want to be able to return to, or seek, appropriate employment and not be discriminated against because they have been ill. In reality, they often find that the struggle after recovery, with an intolerant and uninformed society, is just as difficult as the one which they had with the illness itself.

*Evaluation and Research*

Careful assessment of client needs at the community level is needed prior to undertaking massive new programs. Evaluations should also be instituted as standard operating procedure whenever new treatment approaches are attempted. Demonstration sites are important because new programs can be developed carefully, and they can also be evaluated and studied by others as they change and grow. Attention must be paid to the development of cost-effective programming—programming which is replicable in a variety of settings. Program planning requires coordinated efforts if it is to be effective in the long term. Agencies must communicate and work together to develop and evaluate programs that work.

To meet many of these needs, Texas might develop a forum or center for research and evaluation that would engender innovative thinking. This center could function as an office of technology for mental health which would be concerned with the development and implementation of innovative treatments for the mentally ill in Texas. To function optimally, it should have freedom of inquiry, should not be located in a service setting, but should be in touch with the needs of both the service providers and the consumers. This center would thus be in a position not only to guide the evaluation process, but also to actively disseminate relevant information through linkages with the university system, the primary care system, advocacy groups, and other interested organizations.

*Staffing Issues*

There are many problems and concerns regarding staff training, retraining, retention, and recruitment. As new programs are developed and implemented, adequate attention should be given to the training of staff to administer and provide these services skillfully. Such training is not conceptualized as a single event, but as a process with follow-up, monitoring, and support from the developers of the new program. To facilitate this, it might be possible to develop regional training centers for mental health professionals where training, implementation, and evaluation of new treatment approaches could be provided.

The question of whether or not colleges and universities adequately prepare individuals for work in the public sector with the chronically mentally ill is also an issue. The focus of many professional programs is on

the development of individual psychotherapy skills rather than psychosocial rehabilitation of the severely mentally ill. Counselors and therapists who have received all of their practical experience and internship training in college counseling centers and similar agencies dedicated to working with the less severely disturbed are generally not well prepared to work with the chronically mentally ill who present many unique problems and needs.

Two approaches may hold promise for dealing with this problem. First, there must be active retraining available within those agencies which provide services to the chronically mentally ill so that staff who are interested in working with this population, but who have had little or no exposure to this type of work, can develop the requisite skills to do so appropriately. Second, an effort must be made to alter the curriculum of training programs so that individuals have an opportunity, while doing their professional training, to develop skills which are relevant to work with the chronically mentally ill. Additionally, internships and practica need to be made available in those settings which serve this population. To accomplish these goals, attention must also be given to retraining some of the trainers, since university faculty members often have not been adequately prepared to work with the long-term mentally ill, either.

Training is not the only staff issue, however. The problems associated with high staff turnover, burnout, and difficulties in recruitment are also concerns. Adequate compensation is needed for workers, and this does not always mean simply more money. Workers need to feel that they can make a difference and that they are appreciated. They need to feel that they can advance in the system and be given the opportunities to do so. Workloads must be appropriate and not overwhelming. Bonuses and other incentive plans should be in place to reward the exceptional worker. When these elements are in place in an agency, workers stay longer and work better, and the recruitment of new employees is much easier.

*Funding Issues*

A common theme linking these issues is the need for adequate funding to implement them. While the best programs are not always the best funded, there is a lower bound beyond which a system cannot go without sacrificing quality or diversity. All too often in Texas, because the level of funding for human services has been traditionally low, implementing a new program has meant losing an old one. This has forced many hard decisions and led to much discontent within the system.

A caring community is developed through public education, and community support is essential when additional funds are solicited from the legislature. An increased effort is needed to promote awareness of the needs of the chronically mentally ill in the community. Business leaders, elected officials, and the community at large must be made aware of the

unique needs of this population so they will be supportive of funding efforts. Advocacy groups, made up of consumers, families of consumers, and other concerned citizens, have provided invaluable efforts in this arena, but a need continues for involvement at all levels in the community if the decisions of the legislature are to be impacted meaningfully.

*The Use of Computer Technology*

*Record Keeping*. One "high tech" area of current interest is the use of computers to streamline the medical record-keeping system. As paperwork requirements increase, staff often find themselves spending more time writing about the clients than working with them. This can lead to serious morale problems, disengagement, and rote recording of the same stock phrases over and over without the kind of individualized attention needed in order for a medical record to be truly useful to the caregivers. Computers may be used to alleviate some of these difficulties. The development of menu-driven software packages, for instance, would allow the direct care staff to enter their client notes directly into the computer by using checklists to record those commonly observed behaviors, medication dosages, and responses, while still providing space for short narratives of the more idiosyncratic incidents. This would shorten the record-keeping task considerably while improving the quality of the data entered.

Any such system would have to be introduced carefully and be accompanied by adequate training in order to be effective. The system would also have to be designed for easy use. Staff would have to be shown quite clearly how the system would ease their workload and free them for other tasks. Any fears about computers' replacing jobs would have to be confronted up front. In fact, it might be appropriate to provide salary increases to those individuals who are able to master the new computer-based systems.

*Diagnostic Evaluation and Treatment Planning*. Computers may also provide assistance in both diagnostic evaluation and treatment planning through the development and use of expert systems. In this way, additional expertise could be brought to bear on this vital area of treatment. Although earlier attempts to integrate this type of technology into the medical/mental health field have met with mixed success, many of the problems encountered with those systems can now be overcome. The earlier systems were primarily designed for use on large unwieldy computer systems, were limited in their application, and were difficult to use. Computer technology has changed a great deal in the past decade, however, and new systems are beginning to be available which operate on the same mini-computers that most professonals use in their everyday work.

Assuming such systems could be developed, staff training in their uses and benefits would be essential. Clear guidelines would have to be established to assure that the power of such systems was not irresponsibly and blindly used. Any ultimate decision making would have to be the clear responsibility of the professional, not the computer. Used in this way, the computer could become an invaluable tool to the practicing clinician who seeks to provide the best possible treatment for clients.

*Training and Evaluation.* Other uses of computers could be in the areas of training and evaluation. Interactive systems could be used by clinicians at all levels to improve their skills in many areas of patient service. Computers could also be used to record directly functional assessment data which would then be readily available for use in evaluation and research. This type of structured recording of client data would allow for timely and accurate evaluation of the effectiveness of a given program effort. In general, as computers become easier to use and more powerful, mental health professionals need to be alert to the many possible applications which they might have in this field.

*Summary*

Given the scope of this group's task, it is understandable that the issues covered are numerous. The underlying theme, however, is a sincere concern for the client. Whatever technological advancements or innovations are adopted within a system, such changes must be made cautiously and with regard to the needs of the clients and system into which they are to be integrated. Careful study should precede the initiation of any new programs, and evaluation should then follow to ascertain if the desired results have been obtained. In this era of tight funding, it is necessary that any money which is available be used appropriately, effectively, and efficiently.

# Implementation

Christine Galavotti

At the first meeting of the Commission on Community Care of the Mentally Ill, a consensus was reached that a thorough study of the needs of the chronically mentally ill, including a description of existing resources and service needs, should be conducted. The study is to provide guidelines for the development of policies and programs to improve care for this special population. The role of the Implementation Committee is to ensure that study results are carried out. Strategies for implementation might include educating the public, building coalitions, and lobbying the legislature for increased funding for community services.

## Current Research

The Commission study is a rigorous and independent research document providing statistical support for policy and program initiatives. First, it will describe the need for community facilities for the severely emotionally disturbed and the distinct characteristics and needs of various groups within the population. In the past, there has not been enough solid research of this kind to convince legislators that there is, in fact, an urgent need. Second, the study will describe the existing facilities and resources within communities and the different groups that these programs serve. It is important to quantify and describe the current deficit in services, so that policymakers as well as program planners know what is needed.

Third, the study will provide a definitive statement of program approaches and methodologies to meet the needs of the chronically mentally ill in communities across Texas. It will examine and evaluate different approaches, programs, and service systems in an effort to ascertain which ones work and which do not work. Fourth, a cost evaluation of each of the different treatment approaches will be performed, and the current level of funding for services for the chronically mentally ill will be described for both state hospital and community mental health and mental retardation services.

Information will be given on (1) where the money is being spent and what kinds of services are being provided; (2) what expenditures for the chronically mentally ill are incurred outside the mental health system, such as housing costs and use of other state agency services; and (3) what alternative funding mechanisms might be implemented. In effect, the study will provide a blueprint for a comprehensive state plan.

## The Role of the Implementation Committee

The Commission's mission statement provides a framework for the work of the Implementation Committee and stresses that the target population is limited to individuals between the ages of 16 and 55 "who are suffering from an acute or chronic severe mental illness" and that "the overall strategic plan to be recommended by the Commission will be aimed at shifting the responsibility of care and treatment for the mentally ill from the institution to the community to the extent appropriate."

Implementation of the findings and recommendations of the Commission requires not only that Implementation Task Group members be informed about the study findings and recommendations but also that they be a part of the process of developing those recommendations. This is true for other community leaders as well as Task Group members, since these two groups working together are the link between the Commission and the community. It would be difficult and inappropriate for the Task Group members and the individuals and groups contacted during the implementation process to respond to a finished product and then attempt to carry this standard for the Commission. The implementation strategy needs to be an interactive process involving all the players.

Part of this interaction includes pointing to issues and questions that ought to be addressed in the Commission report and throughout the implementation process. Those issues should include, at the very least, the following items:

1. How will services be funded? To what extent does community care represent a shift of resources from institutions to communities, and what level of increased expenditure can be expected from the state?
2. To the extent that community care of the chronically mentally ill represents a shift in resources, how will conflicts between service providers be resolved? Is it likely, and is it necessary, that all those currently or potentially responsible for the care of this special population agree on how funds should be allocated?
3. How important is the level of funding compared to the types of services? If patients are discharged into the community, appropriate services are needed on the community level, and money is not the only issue.
4. How can training of mental health workers and professionals be improved? What should the emphasis of that training be?
5. How will the special needs of minority patients and their families be addressed? How can these families and organizations be involved in the process of implementation?
6. How can the Commission's findings be most effectively disseminated among the appropriate individuals and organizations?

Who are those individuals and organizations, and how should they be contacted?

7. What is the value of broad public education efforts, and how can they best be carried out? Is it important to concentrate on both public education and gaining votes in the legislature?
8. With regard to funding mechanisms, are there parallels to indigent health care, and could a similar bill providing care for the mentally ill be drafted? What are the advantages and disadvantages of that? Are there other parallels that might be helpful to consider, such as care for the elderly and ways to ensure care in a variety of settings?

This is only a partial list of issues that need to be addressed—that are being addressed by the several committees that form the Commission. Although not all of these issues are directly related to implementation, they are all indirectly related, because implementation will not be accomplished without "implementers"—individuals who are committed to the recommendations that are being advanced. Without being provided the opportunity to discuss those issues and questions most dear to them, individuals and groups will not develop the sense of commitment and ownership required to be effective supporters of the Commission's recommendations. Input from all interested organizations must be solicited.

Early and continuing input into the work of the Commission would further the implementation process as well as enhance and facilitate collaboration among groups. Collaboration is desirable but may be difficult, since there are in fact real conflicts between groups regarding the issues and needs of the chronically mentally ill. For example, although there is a growing consensus among mental health service providers that resources should be moving toward community services for this population, state hospitals may feel threatened by a shift in resources.

These conflicts and concerns underline the importance of early involvement of all interested parties. Points of agreement and disagreement need to be spelled out and effectively resolved in order to present a united front. Whether all groups ultimately agree on every issue or not, community groups, associations, state agencies, and legislators all need to play a meaningful role in the development of the recommendations to achieve the kind of ownership and commitment to the recommendations that will lead to a successful implementation program.

It is also of vital importance to involve and gain the support of others who participate in the life of the community such as church groups, housing authorities, judges, and police. A broad base of support is necessary to the successful implementation of the plan.

A major focus of implementation efforts will be to persuade key people and groups to support the final recommendations, but barriers to implementation exist on many levels. Communities do not see the chronically

mentally ill as their responsibility. A process that would bring a sense of responsibility to the communities might be an important first step. Public education is one way community awareness and support could be increased, but education is not the only important factor. A well-orchestrated lobbying effort might be more likely to translate to dollars for the mentally ill. Still, communities, organizations and local leaders need to be educated about the needs of this group since their support is crucial to any lobbying effort.

Both public education and lobbying efforts should build on information, strategies, and networks that have already been developed. For example, researchers from the University of Houston have been developing a proposal to present for funding in this legislative session that involves designing aftercare facilities for the mentally ill. Several prominent individuals in the field of mental health have been involved in the development of the project and may be valuable resources to the committee. In addition, the League of Women Voters has recently completed a statewide survey that includes information on community perceptions of the needs of the seriously mentally ill. In the process of doing that study, the League was in contact with a number of advocacy organizations and providers of care and has established a network of interested individuals and organizations. Although the final report and recommendations of the Commission will be targeted at the 1991 legislative session, organizations and individuals should be alerted now.

Creative approaches to involving organizations, communities, and families in the implemention process need to be developed. One approach could be a sort of "travelling road show." In collaboration with groups like the Alliance for the Mentally Ill and others, a set of educational materials and presentations could be developed to take to key community groups and decision-makers. This strategy would not only broaden public awareness of the needs and problems of the mentally ill, but it would inform people of, and garner support for, the recommendations to be brought to the legislature.

## Recommendations

A clear sense of direction emerged from the Task Group's deliberations. To assure implementation of the Commission's findings and recommendations, it is essential to involve all the players in the process. As all of the people and organizations that should be brought into the process are identified, a two-phase implementation process can begin.

First, to begin immediately, the Hogg Foundation Commission should begin a series of meetings with each of the major advocacy organizations to lay out the Commission's work and invite input from these organizations.

Platforms developed by the Mental Health Association and the Alliance for the Mentally Ill for the next legislative session are examples of the type of input that should be encouraged. In mid-1989, after the study is complete, a second meeting of the Commission and representatives of each of these organizations should convene to review study findings and to reach a consensus on an overall plan and set of recommendations.

Phase two of this approach would involve setting strategy for implementing the overall plan. One part of that strategy should focus on public education. Materials and presentations should be developed to take to local Mental Health and Mental Retardation boards and other groups to explain the Commission's recommendations and to garner support. In particular, the involvement of local MHMR boards should be sought. A second part of the implementation strategy would involve identifying and working with legislators. Although the Commission intends to target the 1991 legislative session, legislators should be approached much sooner. Early activities might include contacting key legislators during 1989 and 1990 to lay the groundwork for future proposals.

# Collaboration

Leslie Baham Inniss

A central issue in any discussion of community care of the chronically mentally ill is identifying the most effective level of collaboration among community and state service agencies. The Collaboration Task Group was formed to address the critical issue of making mental health service delivery a team effort. Participants in this group explored some of the barriers to and opportunities for working together successfully as well as the legislative measures aimed at integrating programs of various health and human service agencies. The strategic goal for this task group was to make recommendations leading toward the most effective delivery of collaborative services for the chronically mentally ill.

## Summarizing the Work of the Task Group

Collaboration Task Group participants identified five barriers to cooperation and two major areas which offered opportunities for teamwork. The five problem areas are inconsistent definitions, differing interpretations of eligibility criteria, failure to communicate at all agency levels, categorical methods of funding, and an emphasis on "priority populations."

Two areas of opportunity for collaboration are finding the most appropriate levels at which common efforts would be successful and discovering and using incentives for cooperation.

Task Group members also elaborated on national examples of successful collaboration and offered four general recommendations for improving efforts in the state of Texas.

## Barriers to Effective Collaboration

The central theme running through the discussion of barriers was the need for a united operational policy among agencies that serve the chronically mentally ill. More specifically, the identified barriers and possible solutions for overcoming them are as follows.

### *Inconsistent Definitions*

Definitions of "chronically mentally ill" and "disability" are not always consistent. These terms may not mean the same things to agencies that

serve the same clients. It is almost impossible to design collaborative efforts among service systems using diverse definitions.

*Proposed Solutions*. Common definitions of these terms could be worked out and agreed to by all parties in memoranda of agreement which would be disseminated in nonjargon terms to the general public and the legislature.

*Interpretations of Eligibility*

Different interpretations of eligibility criteria, along with the differing levels of resources that influence those interpretations, were seen as a second major barrier to successful collaboration.

*Proposed Solutions*. Increasing the use of everyday language and decreasing the use of jargon and topical buzzwords to describe client populations and service eligibility requirements would help to remove this barrier.

*Failure to Communicate*

This barrier is related to the lack of leadership support for collaboration. A definite need exists for key executives to place teamwork high on their priority lists and to convey this priority to their personnel.

*Proposed Solutions*. Public agencies must be encouraged to endorse the cooperation process. Key executives should provide leadership in encouraging staff to support interagency collaboration.

*Categorical Methods of Funding*

A number of problems center around the different service requirements related to each category of funds. For example, in the Stewart B. McKinney programs for the homeless, multiple federal and state departments and agencies have created differing application and selection criteria for federal programs.

*Proposed Solutions*. The group did not propose any immediate solutions to this problem because of the complexity of federal funding.

*"Priority Population" Emphasis*

It was suggested that the Texas Department of Mental Health and Mental Retardation's emphasis on "priority populations" tends to make that agency unpopular with other service providers that do not have an adequate

understanding of what these priority populations are and that may subscribe to a different set of priorities.

*Proposed Solutions*. The Texas Department of Mental Health and Mental Retardation should be encouraged to be flexible in reconciling its priority needs with those of individual communities.

Opportunities for Effective Collaboration

Quality care for the chronically mentally ill requires a team effort among all mental health service delivery professionals. Suggestions of opportunities for effective partnership included making collaborative tasks part of job descriptions for key executives, designating a liaison officer, and linking dollars to collaboration efforts via grant requirements. Two major areas were identified as having the highest potential for successful collaboration.

*Finding Appropriate Levels*

A major issue that emerged was the need to identify several levels where collaborative efforts could be most successful. The primary theme of these discussions was that each level would be characterized by unique collaboration efforts. For example, at the board level it would be most helpful if members of various boards could meet and construct agreements on collaborative efforts. At the direct service level providers of services could create their own networks of collaboration.

*Encouraging Incentives*

As the subject of incentives developed, it was agreed that improved quality of care for the client must be the major reason for collaboration. Increasing interagency integration of services for the client should provide motive enough for enhancing services. Beyond that basic reason, however, there are other encouraging stimuli for collaboration. For example, money or some other type of resource could be tied to effective collaboration as additional motivators.

Examples of Successful Collaboration

Current successful collaborative efforts were discussed. Task Group members offered many examples of cooperation taking place both nationwide and around the state. These examples seem to have one thing in common: the creativity and "can do" attitude of the people involved. Examples included efforts to collaborate at the board level, at the key

executive level, and at the direct service provider level. [See Martin D. Cohen's paper on the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill.]

Recommendations for Effective Collaboration

Four general recommendations were suggested. These recommendations focus on strategies for improved networking among mental health service delivery systems.

*Existing Memoranda of Agreement or Understanding*

A great deal of misunderstanding exists about what agreements are in effect at the state level and how they are to be implemented. It is therefore suggested that:

- Identification, analysis, and dissemination of information concerning all memoranda of agreement currently in force between health and human service agencies should be undertaken.
- A mechanism should be created for updating this information, possibly through the use of technology or computerized updates.

A key element of the recommendation is that this identification will allow the Commission subcommittee to suggest strategies for meaningful collaboration at all levels.

*Information Sharing*

A statewide resource directory is needed that is specifically related to programs and services for the chronically mentally ill. It should include detailed descriptions of target populations, eligibility criteria, and service descriptions. The Task Group suggested that key people in these service areas should be identified, and their names should be placed in a data base so that access to agencies will be facilitated.

*Public Service Announcements*

Misinformation regarding the chronically mentally ill is widespread. It was suggested that the Hogg Foundation be asked to produce short public service announcements to serve these purposes: to raise positive awareness and encourage collaboration at the local level, to reduce the stigma of mental illness, and to emphasize success stories focusing on the psychology of hope as suggested by Commissioner Jones.

*Legislative Assistance*

Legislative measures could help to facilitate the integration of various health and human service agencies. The Hogg Foundation should be asked

to assist the mental health community in collaborating with state legislators. As a neutral, non-agency-based source of information, the Hogg Foundation could schedule sessions during legislator training, schedule informational dinners, and provide regular updates for legislators on mental health issues.

## Summary

The Collaboration Task Group ended its deliberations on a positive note. Examples of and mechanisms for collaboration efforts had been identified and discussed. The critical goal of offering recommendations for effective collaboration had been reached. The departing message was that successful collaboration among agencies serving the chronically mentally ill in Texas was not only possible but probable.

# Training

Dorinda N. Noble

A vital area of concern in dealing with chronically mentally ill individuals is the training and retention of professionals who are qualified to deal effectively with this population. Recognizing the centrality of such human resource issues, the Task Group on Training examined perceived problems and possible solutions to the critical tasks of professional training. Participants in this Task Group represented a wide variety of experience and orientation to the care of the mentally ill—coming from such backgrounds as academia, law, medicine, social work, psychiatry, mental health administration, psychology, child development, public policy, philanthropy, and work with diverse service recipients such as children and juveniles, the aged, immigrants and refugees, and the mentally ill.

## Outlining the Work of the Task Group

A summary of some of the major concerns regarding training for mental health professionals has emanated from previous discussions of the subcommittee on training, a unit of the Commission on Community Care of the Mentally Ill under the auspices of the Hogg Foundation for Mental Health. These discussions reflected the input of front-line workers, decision makers, and family members of the chronically mentally ill; consequently, they provide important and wide-ranging background information.

- Mental health care professionals constitute the largest work force and budget item of any state agency in Texas.
- Nursing shortages are critical throughout the state, resulting in situations in which persons who are not trained as registered nurses oversee the administration of powerful drugs.
- Several geographical localities of the state, notably rural areas such as West and South Texas, are experiencing difficulties in recruiting and retaining credentialed mental health professionals.
- Language proficiency and cultural variances can present barriers, either in recruiting and retaining professionals who are bilingual and bicultural or when foreign medical graduates are employed.
- Many mental health professionals lack skills in rehabilitation technology, such as case management, social skills training, and family management training.

- Many general hospitals, particularly rural, are downsizing, a reality which results in both relocation problems for staff and service provision interruptions for clients, particularly mentally ill persons needing crisis care.
- Our present system of care for the mentally ill mixes patients who are law offenders with those who are nonoffenders.
- Adminstrators and managers of mental health care facilities frequently lack training and experience in the nature of serious mental illness.
- Allied professionals such as the police, emergency medical technicians, judges, pharmacists, and others who frequently deal with the chronically mentally ill often have little training in the nature and care of serious mental illness.

## Summarizing the Work of the Task Group

The Task Group worked to refine and clarify critical issues for consideration and to suggest possible directions for resolving identified problems. In addition, each member of the group was asked to submit, in writing, the one training issue which she or he perceived as most critical and a direction for solving that problem. The results can be summarized under eight different, though frequently overlapping and always complex, categories of concern.

### *Core Curriculum*

*The Need*. Curriculum content on the nature of serious mental illness frequently is deficient in the education of primary service providers such as psychiatrists, social workers, psychologists, and nurses. In addition, such educational content, which could be quite efficacious, is very limited for ancillary service providers such as law enforcement officers, vocational counselers, pharmacists, judges, and emergency medical technicians. A basic issue to be resolved is the nature of the clinical and interpersonal skills which can and should be taught to mental health professionals.

Core content, however, in order to be usefully integrated by the learner, must be accompanied by knowledgeable faculty input and by opportunities for actualization by the learner. These factors are often missing, as many faculty who teach courses with mental health content have little knowledge of or interest in the chronically mentally ill, and field placement/practicum/residency opportunities for community work with this client population are sometimes worse than no training whatever. In short, linkages between university and community are often poor, if they exist at all.

*Proposed Solutions*. Three levels of training exist: (1) exposure, (2) experience, and (3) expert knowledge. Educators and in-service trainers

must assess what content and level of training is appropriate to impart to the audience. If, in fact, the training of ancillary professionals is to be adequately addressed, involvement in education at the community college level and in accreditation and certification efforts of various professions is essential.

The American Psychiatric Association is currently working on a plan for a core curriculum dealing with mental illness, and this plan bears watching. One recommendation related to this plan is that, because faculty input is so critical in effective teaching, faculty members should spend one-third to one-half of their time working with mental health patients, not simply consulting or supervising students. This feat could be accomplished by the joint hiring of some faculty members by the community mental health center and the university. Residents in psychiatry could also be required to rotate through community psychiatry clinical training sites, such as mental health centers, for at least six months of hands-on experience. Consequently, the centers would be enriched as sources for clinical research.

Various mental health professions could also work with universities to develop a state plan to ensure that education of future professionals is roughly consistent across the state. Such a plan could include the development of "model" training centers which offer hands-on opportunities for students under supervision and clinical opportunities for faculty.

### *Collaboration*

*The Need.* Because delivery of mental health services is an interdisciplinary effort, it is critical that professionals work together as a team. Collaboration is not without problems, however. For instance, there is some resentment of psychiatry in its traditional role as medical authority in both community mental health settings and institutional settings. Ancillary professionals sometimes feel resentful if they deliver most of the necessary services but must have a psychiatrist sign off on their work. Others in an agency may resent the salary discrepancies that exist between staff psychiatrists and other mental health professionals when they do similar work. In addition, some agency staff may believe that those psychiatrists who work for the agency at comparatively good pay, but stay on board for only short durations before going on to more lucrative work, have not given fair return on the investment of the organization.

*Proposed Solutions.* One possible solution to this problem lies in the area of education of various professionals. Developing attitudes in education that encourage collaboration and emphasize interdisciplinary training—what can be termed "egalitarian training"—would help to modify feelings of turfism. One obvious setting in which to accomplish this

goal is in community centers where professionals must work collaboratively with persons suffering from mental illness.

Professonal education, however, is a lifelong process. Every public mental health program should set aside significant amounts of funds to continue the education of its employees and do so with an emphasis on interdisciplinary training. The critical factor to imparting a team spirit to mental health professionals, however, is to train the trainers of these various professional groups to work with each other in a collaborative fashion.

*Work Conditions*

*The Need.* A number of problems exist in work conditions for mental health professionals: cumbersome paperwork and accountability requirements, lack of adequate vocational ladder systems, pay scales that vary widely between different professions, lack of opportunities to gain management skills in mental health administration, burnout, and lack of time and opportunity to ventilate concerns and to receive relevant on-going training or advanced education. These problems contribute to the large move from work with chronically ill patients to work settings such as private practice, in which the professional could work with worried well clients.

*Proposed Solutions.* It is very difficult to reduce paperwork in an age of accountability, but creative thinking could hold potential answers. Perhaps the most useful alternatives lie in modern technology: Optical scanners and word processors can decrease paperwork. However, people must be trained to use these technological advances appropriately.

Increasing linkages between the university and community mental health settings can provide opportunities for staff education. In addition, some agencies may wish to assign their employees to an educational setting as a way of encouraging further training which is useful in agency work. Vocational ladders, particularly for such employees as mental health aides, can be designed and implemented. Problems of burnout, particularly in settings of high patient density, must be addressed by the encouragement of ventilation and discussion opportunities and by the hiring and retention of management and administrative staff who understand the unique difficulties of working with the chronically mentally ill.

*Client Considerations*

*The Need.* A number of considerations center around the client. Paramount among these is the need to help professionals develop sensitiv-

ity and competence in cross-cultural work. Other special client situations, however, desperately need professional attention, such as the needs of the mentally ill who are aged, who are hearing-impaired, who are refugees, who are children, who are prisoners, who are autistic, or who have AIDS.

*Proposed Solutions.* Texas Department of Mental Health/Mental Retardation is considering establishing a unit to address the culturally diverse needs of the mentally ill population. Part of the focus of this proposed unit would be to examine potential institutional barriers to access of appropriate mental health services, barriers which may lead to underutilization of services by ethnic/racial minorities. In addition, such a unit can also deal with problems of refugee populations, particularly Asian and Hispanic persons.

TDMHMR may wish to analyze its hiring practices and advancement opportunities to determine if minority group members and women staff have adequate access to decision- and policy-making processes. From another perspective, however, the total answer to this problem does not lie in training more and more persons of minority status; mental health workers must, in fact, be trained and retrained to develop cultural sensitivity.

Language barriers present serious problems to both professionals and clients. Staff should be trained in basic Spanish, suitable for triage methods, so that they can have adequate information with which to make appropriate crisis decisions. Mental health professionals in the state can also benefit by staying abreast of the progress of a program funded by the Robert Wood Johnson Foundation at Tropical Texas Mental Health Center, a project aimed at developing culturally relevant services.

The demand for care for the mentally ill who are aged or who have debilitative illnesses like AIDS will continue to increase. It is critical for mental health professionals to be aware of the policies and practices of day-care facilities, nursing homes, and long-term care facilities that serve many chronically mentally ill persons with physical health conditions.

In addition, in-service training for staff working with these special populations would be enhanced by interesting and understandable videotape presentations. TDMHMR and/or universities could develop traveling teams of experts to address treatment issues concerning these patients for in-service staff training.

### *Outcomes*

*The Need.* A continuing need in the care of the mentally ill is for better data regarding outcomes of treatment and evaluation of programs. Evaluation (determining what has value) is an underutilized, poorly developed, but essential aspect of program development.

*Proposed Solutions*. It is hypothesized that one reason that evaluation of care of the mentally ill is lacking is that the field has low status in academia; consequently, many of the professionals who go into this field are poorly trained in general and in the evaluation research methods of the field in particular. The notion of developing greater collaboration between universities and community mental health settings offers possibilities of creating an environment in which evaluation skills and program design can meet. A commitment to evaluation and training in evaluation methodologies is thought by many professionals to be long overdue.

*Shortages of Professional Staff*

*The Need*. Across the state many rural or scattered settlement areas, as well as border communities, suffer a shortage of adequately trained and credentialed professional staff. This shortage seems to result from the fact that too few professionals are attracted to work with the chronically mentally ill, and of those who are interested in such work, the number who are attracted to smaller communities is inadequate to meet the needs of those areas.

*Proposed Solutions*. This problem must be dealt with on both long-term and short-term bases. A long-term effort involves creating some formal structure, as through a university, to identify high school and college students who are interested in care of the mentally ill and to offer experiences which will expose them to this career field. Universities can offer innovative ideas about how these experiences can be developed. Universities can also help develop attractive stipend programs and other incentives for students who are possible mental health professionals. In more general terms, mental health professionals can serve as role models to persons who are involved in personal career decisions and who might be interested in mental health services.

Shorter-term solutions must address current staff shortages. One suggestion centered around a sound analysis of staff distributions across the state, identifying the areas with the gravest shortages and creating innovative enticements to those areas. One of those enticements can be generous payback agreements, in which students are assisted by mental health agencies to acquire education, later paying the agency back with service time. TDMHMR is a structure already in place with clinical sites; however; if TDMHMR provides more than in-service training, (1) the money which the agency gives out should have strings attached to it, so that students will actually render service to the limit of their commitment, and (2) the money should go for education services. Moreover, rural areas can also be assisted in "growing their own" by aiding persons already living in the area to become trained and credentialed.

*Skills and Knowledge*

*The Need.* New knowledge and skills are needed for effective treatment of the mentally ill. Two areas are particularly important: work with families of the mentally ill and work with alcohol/substance abusers.

Professionals can benefit by developing expertise in working collaboratively and sensitively with families of patients and with support groups of those families. In addition, professionals can enhance the services they deliver by working together more effectively. For example, many chronically mentally ill victims medicate themselves with alcohol and drugs. Yet there is often limited interfacing between those professionals who work with the mentally ill and those who work with substance/alcohol abuse. This dual-diagnosis group appears to be growing. Indeed, the current Texas commitment laws and payment schedules force physicians to use "creative diagnoses" to deal with dual-diagnosis patients; many of them end up in state hospitals.

*Proposed Solutions.* The coping skills of families are important, whether their affected members are single- or dual-diagnosis patients; these families often develop useful coping and networking skills. Professionals should examine these skills in greater depth and add them to the professional arsenal of tools. Demonstration projects centered around "mutual self-help" should be encouraged to build on the innate strengths of patients and their families.

Skills relating to dual-diagnosis patients are in an embryonic stage. A Dane County, Wisconsin, program conducts dual-diagnosis groups which are co-led by drug counselors and mental health professionals. Under this program, if patients appear to be using Supplemental Security Income payments to purchase drugs, the county can designate payees so that SSI grants can be monitored. The payees then pay large bills (such as rent) for the patient and give money or vouchers for food on a daily basis. Such an approach presents clear ethical dilemmas, however.

The development of relevant, timely, and easily understandable ongoing education to train staff and ancillary professionals about this important topic of dual diagnoses is also needed. Despite varying approaches to the problem, it is clear that mental health professionals must face the growing needs of dual diagnosis clients.

*Policy Initiatives*

*The Need.* Presently there are a number of matching funds opportunities available to this state to improve service delivery; yet the state is not taking full advantage of all these opportunities. In addition, the standards for nursing homes, day-care homes, and similar facilities are being altered

without the benefit of direct input from a wide variety of mental health professionals. These are facilities that are receiving increasing levels of funding and which often serve the chronically mentally ill.

*Proposed Solutions*. Mental health professionals need to become more aware of issues such as facility standard-setting processes and governmental funding patterns. For instance, endorsement by professionals of Title VII of the Public Health Reorganization Act, which offers 2.2 million dollars of start-up monies for Health Education and Training Centers, may be appropriate. San Antonio is a Texas city presently taking advantage of this opportunity. The program is aimed at helping medical schools develop programs to train professionals in border areas, Appalachia, the inner cities, underserved rural areas, and the Caribbean basin. Presently the state of New Mexico is developing such a center for mental health training.

Rewards for the Work of Mental Health Professionals

The Task Group came to the end of its deliberations with some optimistic words for the future. People with expertise in working with the chronically mentally ill are avidly sought for top-flight job placement opportunities. In addition, working with this client population offers many rewards. The professional really gets to know the patients; in fact, the professional can almost become substitute family for the patients. In addition, the environment of working with a team of other professionals toward a common goal is stimulating and enriching. In a sense, working with this client population is like being a general practitioner—the professional gets immersed in the environment, the family, and the community of the client and of the community mental health setting. In short, despite the low social status of the patients, and despite the energy required by the work, it is a career field that offers many rewards to its professionals.

## Commissioned papers

Kanter, Arlene S. "Current Issues in Mental Health Law"

Cohen, Martin D. "Model Programs for Persons with Chronic Mental Illness: Overview of the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill"

Holzer, Charles E. III, Jeffrey W. Swanson, Vijay K. Ganju, Harold F. Goldsmith, and David J. Jackson. "Estimates of Need for Mental Health Service in Texas Counties"

Warner, David C., Laurie Crumpton, and Gary Watts. "Financial Costs of Caring for the Chronically Mentally Ill in Texas"

Pharis, David B. "State Hospital Reform in Texas: A History of the *R. A. J.* Class Action Lawsuit"

Hicks, Regenia. "Children's and Adolescents' Mental Health Needs in Texas: A Time for a Vision"

Johnson, Carmen Acosta, and Dale L. Johnson. "Families of the Mentally Ill in Texas"

# Current Issues in Mental Health Law

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## Introduction

Mental health law has come of age. In the past two decades the field of law concerned with the rights of people with mental disabilities has grown dramatically. The federal and state courts, the Congress, and state legislatures have discussed and in some cases created new rights and obligations for people who are labeled mentally ill.

Much of the discussion has focused on the debate between psychiatrists and advocates about compulsory treatment. Psychiatrists charge that protecting people from compulsory treatment leaves them to "die"[1] or "rot"[2] with their rights on. The other side is often equally accusatory, referring to patients as "prisoners of psychiatry."[3]

But while this debate continues, the challenge of providing much-needed services to people with mental illness—voluntary or not—remains largely unmet. The number of homeless people in need of housing, social support, and treatment vividly illustrates the need for advocacy. Some have called for return of the "asylum"—to rehospitalize people who are unable to make it on their own. Yet such proposals are simplistic at best. As John Talbott has written, the choice between rehospitalization and homelessness "is like choosing death by strangulation or death by drowning."[4]

Developing needed services in the community has been difficult. Reliance on the courts and legislatures for adequate systems of mental health care has met with mixed success. Such systems are expensive, and legislatures are generally reluctant to mandate new spending. Courts vary in their approach. Some judges will aggressively protect individual rights and entitlements, ordering the provision of services at any cost. Other courts are either baffled by the legal issues in mental health care or unwilling to order expenditure of state funds. Further, even if courts recognize violation of a legal right, few involve themselves in implementation—a process that is tedious at best and fraught with political, adminstrative, and legal pitfalls.

Yet despite these apparent obstacles, much has been accomplished in recent years. On the federal level, courts and Congress have struggled with difficult questions around the rights of people with mental disabilities. Such struggles have often resulted in the establishment of new legal rights

or the expenditure of substantial resources. On the state level, courts and legislatures have considered such difficult issues as the proper standard for commitment and the practicality of outpatient commitment, referring to an individual's court-ordered treatment in the community.

This paper will explore the developing law with respect to mentally ill individuals' rights to services and treatment, both in and outside of hospital settings.

## The Right to Treatment in the Hospital and in the Community

Any discussion of developments in mental health law must begin with a look at the wave of lawsuits brought against mental institutions in the 1970s. Landmark lawsuits, relying on novel constitutional theories, established the rights of people with mental illness as well as developmental disability to treatment and protection from harm,[5] to procedural and substantive protections in the civil commitment process,[6] to safeguards against intrusive and hazardous procedures such as sterilization or forced medication,[7] and to appropriate community services.[8] The legacy of these cases is a growing body of law governing institutional treatment, which has spawned many class actions and individual lawsuits.

The first case addressing the right to treatment was *Rouse V. Cameron*,[9] in 1966. Rouse was committed to Saint Elizabeths Hospital in 1962 after being found not guilty by reason of insanity for a misdemeanor punishable by a one-year maximum sentence. After three years of hospitalization, Rouse petitioned for release on the ground that he had received no psychiatric treatment. The court granted his petition, holding that the "[p]urpose of involuntary hospitalization is treatment, not punishment. . . . Absent treatment, the hospital is transform[ed]. . . into a penitentiary where one could be held indefinitely for no convicted offense."[10] While the decision was hailed as a victory by those who viewed it as a step forward in reforming the deplorable state hospital where people were confined, then forgotten, it was not until *Wyatt v. Stickney*[11] that the right to treatment emerged as a fundamental legal doctrine.

In *Wyatt v. Stickney* a United States district court in Alabama made history by ruling that mentally handicapped persons involuntarily confined to a state institution have a constitutional right to treatment. The case began as an effort to stop the state from firing hospital employees because of budget cuts. After studying the record and touring the hospital, Judge Frank M. Johnson, Jr., declared in 1971 that the dreadful conditions there violated civilly committed patients' constitutional right to treatment. He wrote that "involuntarily committed patients unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or improve his or her mental

condition."[12] The court went on to state that "to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the fundamentals of due process."[13]

Accordingly, one year later a detailed consent decree was adopted, requiring compliance with specific standards on such matters as floor space, toilet doors, and other living arrangements. The decree also imposed patient-staff ratios, required detailed individual treatment plans within 48 hours of admission, prohibited excessive medication and the use of medication as a punishment or for staff convenience or as a substitute for programs, required that work done by patients must be voluntary and compensated at minimum wages, restricted physical restraint and isolation, and guaranteed to patients their right to privacy, mail, phone, and visitors.

The legal theory in *Wyatt* and its progeny is straightforward: When the state deprives an individual of liberty in order to provide treatment, it has an obligation to provide that treatment. Nonetheless, *Wyatt* was criticized sharply as improperly encroaching upon the psychiatrist's purview—criticism that was repeated following the Supreme Court's historic decision in establishing the right to liberty, in *O'Connor v. Donaldson*.[14]

Kenneth Donaldson had been civilly committed and confined for 14 years when he sued state hospital psychiatrists for damages, alleging that members of the hospital staff had intentionally and maliciously deprived him of his constitutional right to liberty. On June 26, 1975, the United States Supreme Court unanimously held that patients "who are not dangerous to themselves or others, are receiving only custodial care and are capable of surviving safely in freedom or with the help of family or friends" could not be institutionalized against their will.[15]

The next step after *Wyatt* and *Donaldson* in the Supreme Court came in 1982 with the Court's decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982). In *Youngberg*, the Court was, for the first time, presented with the task of outlining the scope of the rights of people with mental retardation under the Fourteenth Amendment to the United States Constitution. In *Youngberg*, an institutionalized person with mental retardation, through his mother, sued the state claiming his constitutional rights had been violated by the state facility's failure to provide him with adequate treatment and by the facility's use of inappropriate treatment, including mechanical restraints. The Court, in a unanimous decision, held that the substantive rights provided by the United States Constitution define only the minimum. Although the resident had a constitutional right to training in basic self-care skills to help minimize his aggessive outbursts consistent with his liberty interest in avoiding frequent restraints, as well as certain limited rights to adequate food, shelter, clothing, medical care, safety, and

freedom of movement, none of these rights was "absolute." According to the Court, these rights are subject to implementation consistent with "professional judgment." In short, the Court failed to recognize a per se right of people with mental retardation to treatment or to be treated in the least restrictive environment. The issue is still unresolved, however, for people with mental illness.

In two other cases, courts have established a right to treatment in the least restrictive setting for residents of state mental hospitals. In *Brewster v. Dukakis*[16] and *Dixon v. Weinberger*[17] patients confined to state hospitals brought class action lawsuits to establish that they had a right to placement in less restrictive settings outside the hospital—in particular, placements consistent with their treatment needs. Such a right presumes the state's continuing responsibility to provide basic care, shelter, and other necessities while retaining the minimum amount of control over the individual. Conflict arises, however, when the state is ordered to develop services in the community in order to allow the individual to leave the institution.

*Brewster* was filed in 1976 on behalf of institutionalized and noninstitutionalized people in the western part of Massachusetts. The case was brought to compel the state to implement a 1966 state law empowering the Department of Mental Health to create a comprehensive system of community programs instead of enhancing services in the large state hospitals. *Brewster* was settled in 1978, and its effect has vastly improved community-based services in western Massachusetts.[18]

Filed in 1974, *Dixon* sought to establish that under the United States Constitution and District of Columbia statutes patients at the federally operated St. Elizabeths Hospital in Washington, D.C., had a right to treatment in less restrictive facilities, consistent with individual needs. On December 23, 1975, the federal district court held that the city and federal governments had a joint obligation under D.C. law to provide suitable care and treatment outside the hospital to all patients who did not require hospitalization. The court ordered both defendants to develop a plan for the creation of a continuum of community-based facilities as the basis of a remedial order.[19] After lengthy negotiations a plan was accepted and approved by the court in April 1980. The plan and accompanying consent order represented a major effort to address the many and difficult problems involved in implementing such a judicial order, including sound planning for the necessary changes, convincing the bureaucracy to accept changes, and designing an effective monitoring system to ensure compliance.

The settlement required the city and federal governments to assess the needs and capabilities of every patient and set standards for mental health care, adequate and appropriate residential services, and support services in the community. In sum, the decree, with its accompanying plan and standards, is a model for a comprehensive mental health system. Never-

theless, its goals have not been realized. Even after contempt proceedings the local government has been slow to dedicate the resources and effect the structural changes necessary to implement the decree.

Cases that have followed *Dixon* and *Brewster* in seeking to establish the right to treatment in the community illustrate the continuing uncertainty about the scope of remedies. Approximately half of the states now have laws that require habilitation, normalization, or the provision of services in the least restrictive setting for people with developmental disabilities or mental retardation. By contrast, fewer than 15 states have statutes requiring or even encouraging services in the least restrictive environment for people with mental illness, and of those only three create entitlements to deinstitutionalization and community services. Accordingly, many people who could benefit from care in a community setting find such care unavailable.

One reason is money. The vast majority of states' mental health dollars remains tied to hospitals, leaving few community care options available to discharged patients. Yet the state mental hospitals serve a diminishing proportion of the people who are mentally ill. Almost 70 percent of public mental health dollars ($4.1 billion) was spent on state hospitals in one recent year,[20] although most people who need emergency inpatient care are treated as psychiatric admissions to general hospitals, Veterans Administration facilities, or private hospitals.[21] And those who need noncrisis services are theoretically treated in the community where they live.[22] But because people with mental illness often have no resources and their caseworkers can seldom find a community agency that will provide them future care, discharge too often means return to the streets.

Access to quality mental health care cannot improve, therefore, unless the resources shift from the state institutions to the community. In Louisiana, for example, 103 state hospital patients were discharged into the community, and six wards were closed. More than one million dollars were saved, and the allocation was permanently transferred to support community programs for the 103 patients and others. Even the closing of state hospitals is now being seriously entertained. In Vermont, a recent study recommended closing the state's only mental hospital and using the savings to help pay for community programs.[23]

Federal courts have generally been unwilling to reallocate mental health dollars from institutions to the local level in part because of their unwillingness to recognize a constitutional right to mental health treatment in the community.[24] However, a more common and so far more successful strategy for the reallocation of mental health dollars has been state court litigation.

Lawsuits filed in state courts ask the courts to hold that laws requiring specific services be considered an obligation the state government cannot

abandon, even if funds for those services are lacking. State courts have generally seemed hospitable to such suits challenging the failure to implement mandatory community programs. For example, in a recent Arizona case, the plaintiff class, indigent mentally ill residents of Maricopa County, asked the state court to compel the Department of Health Services, Arizona State Hospital, and the County Board of Supervisors to perform duties required by state mental health law, which include creating a unified and cohesive system of community mental health care. Although the defendants claimed inadequate funds, the lower court ordered them to fulfill their mandate.[25] *Arnold v. Sarn* is the first decision by a state court to order the development of a comprehensive system of care for chronically mentally ill people.[26] The case is now on appeal to the state's highest court.[27]

The *Arnold* decision is particularly instructive regarding the factors necessary to create such a system. Using as one model the consent decree in *Dixon*, the court ordered the following services as necessary for the operation of an effective system: case management, residential services, day treatment, outreach, medication, outpatient counseling, crisis stabilization, mobil crisis services, socialization, recreation, work adjustment, and transportation. In fact, the court specifically recognized that deinstitutionalized individuals are often at risk of rehospitalization because the residual impairments of their illness interfere with successful adjustment to community life unless they have adequate community mental health services. Accordingly, the court further ordered the Arizona State Hospital to ensure that discharged patients have a place to live as well as an adequate program for necessary treatment.

In addition to the *Arnold* case, *Klosterman v. Cuomo* is a case that, if successful, will result in services for mentally ill people who are homeless.[28] Nine patients discharged from New York State psychiatric facilities into shelters or onto the streets claim violations of their federal and state constitutional and statutory rights to treatment and housing. The state court held that the plaintiffs had no constitutional right to treatment because they were no longer patients of state mental hospitals. The constitutional right to treatment in the least restrictive environment, the court said, applies only when an individual is under restraint or otherwise confined. The defendants also sought dismissal of the suit, but the court held that the plaintiffs could challenge both the state's failure to prepare written service plans for each discharged patient and its differential treatment of current and former patients. According to the court, if the state provides community care to patients discharged from psychiatric facilities but not to severely mentally ill *former* patients, then the plaintiffs had a claim under Section 504 of the Rehabilitation Act, which prohibits

discrimination on the basis of disability by any program that receives federal funding.

Yet advocates cannot expect that by obtaining a court order they can ensure an adequately funded system of community-based care. In *Mental Health Association v. Deukmejian*[29] a California court denied relief to two plaintiffs who sought release from a state mental hospital alleging a constitutional right to treatment in the community under the California constitution and state law. Although California law creates a legislative preference for mental health treatment in the least restrictive setting, the California Superior Court held that the statute did not create an absolute right to such treatment. Despite extensive evidence of the deficiencies of the hospital-based system, the court refused to determine how the mental health system should be constructed and funded. It held that states should have considerable latitude in deciding how mental health services should be provided and whether these services should be provided at all. Indeed, it is possible that state courts will not require defendents to do more than actively seek funding from the legislature.

## Housing as the Critical Need

In addition to mental health services, many mentally ill people are in desperate need of housing. Without adequate housing or a permanent address many could not even take advantage of services offered. Yet the combined effects of stigma and economic restrictions have prevented the development of housing options, from group homes to supported independent living units for people with a mental disability.

In addition to actions seeking to compel local and state governments to finance community care, litigation has been brought to keep barriers unrelated to funding from inhibiting the development of community services. These cases generally involve challenges to zoning laws and restrictive covenants.

Literally hundreds of cases in state courts have considered whether a zoning permit was properly withheld from a provider seeking to open a group home or whether a restrictive covenant limiting the use of land to single families could lawfully exclude group homes for people with mental disabilities.[30] In the past couple of years, however, strategies to expand housing for people with mental disabilities have moved beyond traditional zoning battles.

In 1984 the Supreme Court decided *Cleburne v. Cleburne Living Center*,[31] rejecting a city's denial of a permit to open a group home for 13 mentally retarded adults. In a 6-3 decision the Court upheld the right of a group home to open, concluding that the city's ostensible justifications for

denying the special-use permit were either impermissible or unworthy of belief.[32]

Since *Cleburne*, additional cases have rejected efforts to restrict development of housing for people with mental disabilities. A federal court in Florida declared unconstitutional several provisions of a Miami Beach ordinance regulating "adult congregate living facilities." The operators of an adult congregate living facility were denied a special-use permit because the proposed facilities exceeded four stories and were located on streets prohibited by the ordinance. The operators sued, and the court held that, under *Cleburne*, the city's zoning ordinance was unconstitutional because, for no rational reason, it treated residences for disabled people differently from those for other groups.[33]

A similar suit was recently settled in the United States District Court in Ashland, Kentucky. In this case the city responded to a provider's application to open a group home by rezoning the street on which the home was to open so as to prohibit multifamily uses. When the provider then tried to build and operate an apartment complex for mentally ill and non–mentally ill people, the city rezoned the entire city to prohibit the proposed building. After a suit was brought by the prospective residents and the provider, claiming that the city's actions constituted blatant discrimination against people with mental illness, the city agreed to rescind its changes to the zoning laws and to grant the necessary permits.[34]

## Imposing Treatment

### *Relaxing Civil Commitment Laws*

Financing an adequate mental health system and developing housing for people with mental illness are difficult tasks which can take a long time. Some commentators and psychiatrists are calling for quicker "solutions" by changing state civil commitment laws ostensibly to ease the burdens on the community systems.[35] Currently, most states allow involuntary commitment only to individuals who are considered dangerous to themselves or others. In practice, this standard requires that the grounds for commitment be established by objectively verifiable criteria. Some critics of deinstitutionalization would like to see these standards relaxed so that people could be moved "off the streets...and back in facilities designed for people in their condition."[36]

The American Psychiatric Association, in its comprehensive report on the homeless mentally ill, has hailed such attempts to allow homeless people to be committed more easily, under a standard that would permit the commitment of anyone who is "likely to suffer substantial mental or physical deterioration."[37] This alternate standard focuses on whether the

person is capable of tending to his or her own physical needs rather than on imminent or potential dangerousness. It also places decisions regarding commitment in the hands of the medical profession rather than those of the legal community.

This movement toward "reinstitutionalization" is seen by some as responsive to the needs of families who have had to stand by helplessly and watch a loved one slowly degenerate into a seriously disabled person, without being able to provide treatment because the individual refuses.[38] By requiring a court to order involuntary commitment when it concludes that the person "lacks the capacity to make an informed decision concerning treatment," the APA model law permits treatment of involuntary patients without their consent. The drafters of this proposal defend this provision by stating the patients have the right to treatment that is "the most appropriate and therapeutic available." To some, returning people to mental hospitals is "a simple solution to the problems of deinstitutionalization such as homelessness."[39]

Yet the movement to broaden the grounds for involuntary commitment does not respond adequately to the real needs of people who are homeless for decent housing, rehabilitation, and other services. In fact, it may have serious implications for both homeless and nonhomeless people.[40]

The argument for changing commitment is also inconsistent with current trends in mental health care. While it is true that since 1955 the number of residents of state mental hospitals on any given day has dropped from 559,000 to 120,000,[41] these hospitals are not empty. Many mental hospitals have become, instead, short-term, acute care facilities.[42] In fact, inpatient psychiatric admissions to both state mental hospitals and psychiatric wards of general hospitals have risen to approximately one million a year.[43]

In addition, there is little evidence to suggest that the current civil commitment standards actually prevent people from receiving treatment in mental hospitals. Other factors, such as medical decisions not to hospitalize and the lack of available beds, may play a larger role.[44]

Finally, someone who is committed (regardless of whether existing or proposed standards are applied) will eventually be discharged, often within 20 days.[45] Most states resist increasing their inpatient population, in part because the cost of inpatient care is high and because long-term inpatient care is simply not clinically indicated in most cases.[46] Committing more people, then, may simply strain hospital resources without securing care for people who may be sick. Indeed, current standards requiring dangerousness for commitment cannot adequately determine who does or does not need treatment. There is therefore no guarantee that less stringent standards will not suffer from the same inexactitude.

*Outpatient Commitment*

Some states are also considering enactment of so-called "outpatient commitment" for people who do not require hospitalization. Outpatient commitment, as currently used, refers to the procedure by which an individual is ordered by a court to receive treatment in the community although he or she does not meet the state's standard for civil commitment.[47] This procedure has recently been enacted in several states, including North Carolina, Hawaii, and Georgia and, in slightly different form, in Tennessee.[48]

Outpatient commitment proposals may be well intentioned, seen as a way to help someone obtain treatment and avoid institutionalization. Most such laws have been put forth by those concerned about "revolving door" patients—people admitted to a mental hospital, stabilized, and then released, often to shelters or the streets, only to be readmitted again and again. Yet outpatient commitment laws, like the proposals calling for relaxation of commitment laws, will simply not solve the problems they attempt to address.

First, outpatient commitment laws have been proposed as a way to reduce the money spent by states to maintain large state hospitals, based on the assumption that community treatment is less costly than hospital-based care. Such an assumption is correct, but not if the community treatment is mandated indefinitely. As one doctor in North Carolina has stated, a mentally ill person subject to an outpatient commitment order "will stay with us forever," requiring the state to pay for continuous treatment.[49] Accordingly, the state will be forced to pay not only the cost of care for people who are hospitalized under existing commitment laws, but also for those who are required to receive outpatient services on a daily and indefinite basis.

Some states are charging the patients for care. Yet the fundamental problem associated with deinstitutionalization has been the state's failure to provide and adequately fund mental health services in the community. Shifting the fiscal burden to the patient, especially the indigent patient, will not alleviate this problem.

In addition to costing the state money, outpatient commitment may create new problems for a person with a mental illness.[50] First, it is unclear how a court may order a person to comply with outpatient treatment in a state that recognizes the right of a competent mentally ill person to refuse treatment, which many states now do. The "right to refuse" doctrine is based on the traditional theories of the right to privacy and of informed consent, which provide that a person may be treated without consent and against his or her will only if the person is shown to be incompetent—i.e., incapable of making an informed treatment decision. If a person is found incompetent, a guardian must be appointed to make decisions on his or her

behalf. In the context of outpatient commitment, this creates a paradox: A judge can order a person to do something that he or she has a legal right to refuse to do.

Further, it is well established that the greater the infringement of liberty represented by the state action, the more procedural protections must be afforded an individual before he or she may be subjected to the state action. Such protections include the right to notice of the state's proposed action, the right to an attorney, the right to a hearing before a judge within a certain number of days, and the right to cross-examine witnesses. States vary in the protections they provide. But is is clear that someone who is subject to an outpatient commitment order suffers a significant deprivation of liberty and should therefore be guaranteed at least the procedural protections accorded individuals in proceedings for civil commitment as an inpatient.

Finally, it is not evident exactly what type of penalty, if any, will be imposed if a person fails to comply with the terms of an outpatient commitment order. Will the person be sentenced to jail for contempt of court? Or sent to the state mental hospital? Some states have dealt with this issue by choosing *not* to deal with it, including no enforcement mechanism in their state outpatient commitment statutes. Others, such as Tennessee, provide that a person can be institutionalized for failing to comply with an outpatient treatment plan, but only after a court hearing.

### *Taking Homeless People off the Streets*

The United States Supreme Court has recognized that "[a]mong the historic liberties . . . [is] a right to be free from . . . unjustified intrusions on personal security."[51] The Supreme Court has also stated that "[n]o right is held more sacred, or is more carefully guarded than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear or unquestionable authority of law."[52]

On the other hand, the individual's liberty interests in being free to decide to seek or refuse medical care or shelter must be balanced against the countervailing interest of the state in the treatment and care of people who are incompetent, under its *parens patriae* or parental power, and in using its police power to protect the public health and safety.

Historically, the state's *parens patriae* power authorizes the state to act on behalf of minors and people who are incompetent to make their own decisions concerning personal safety and welfare.[53] Thus the state may legally exercise its power to assist incompetent people.

The state also has a right to protect the health and safety of its citizens. The courts have strictly limited this police power, however, to the extent that it is exercised at the expense of an individual's liberty interests.[54] In balancing the interests of the state and the individual, courts have weighed

such factors as the level of intrusion of the person's liberty, the degree of societal harm, and the level of certainty that state intervention will prevent such harm. For example, courts have upheld requirements of vaccination to prevent epidemics,[55] laws requiring that helmets be worn by motorcyclists,[56] and mandatory fluoridation of the water supply.[57] In other words, the state's interest in saving the lives of its citizens may justify the intrusion of coercive treatment or confinement in a shelter.

However, where the harm to the individual (such as the harm to a homeless person remaining on the street) is more speculative and less imminent, the state would have greater difficulty justifying the level of intrusion involved in involuntary treatment or confinement. As mentioned above, the Supreme Court held in the *Donaldson* case that without additional justification the state has no right to confine a person who is not dangerous to others and who is capable of surviving safely in freedom by him- or herself or with the help of willing and responsible family members or friends.[58]

In New York City the mayor has put these principles to the test. He has ordered the police to transport homeless people to emergency rooms of a municipal hospital for psychiatric or medical evaluation when the temperature drops below freezing.[59] The policy raises many questions. Although designed to protect a homeless person from freezing to death, it may cause more problems than it solves.

Outreach to people who are homeless and mentally ill is extremely difficult. They often hide, purposely not to be found. However, experience has shown that homeless people, including homeless people who are mentally ill, generally manage to satisfy their essential needs. They become familiar with a network of "services" and develop a pattern of supportive living, finding food at soup kitchens or from mobile teams and passersby and shelter in doorways, on heat grates, and in subways and bus terminals.[60]

On October 28, 1987, Mayor Koch's policy was challenged. New York City psychiatrists took Joyce Brown (a.k.a. Billie Boggs) from the sidewalk where she had lived for nearly a year and a half, brought her to Bellevue Hospital, injected medication, and confined her in a locked ward. Ms. Brown had been examined at psychiatric emergency rooms at least five times that year and found not to require involuntary hospitalization. The city's own statistics revealed that nearly half of the 215 people brought to emergency rooms from the street by city psychiatric teams in 1988 were found not to require hospitalization.

Subsequently Ms. Boggs challenged the mayor's policy and a lower court agreed. However, the lower court's decision was reversed by an intermediate state appeals court, which held that Ms. Boggs was mentally ill and needed treatment to prevent serious harm to her well-being.[61] It is

well established in New York that "a person may be involuntarily confined for care and treatment, where his or her mental illness manifests itself in neglect or refusal to care for themselves to such an extent that there is presented serious harm to their own well-being." The appeals court found significant evidence that Ms. Boggs was in need of such treatment. Consequently she was involuntarily committed. Once back in the hospital, Billie Boggs refused medication. She went back to court, and the court agreed that under New York law she could not be forcibly medicated in nonemergency situations. The hospital then released her because they could not treat her with medication against her will.

*Refusing Medication*

The right to refuse treatment, particularly medication, is unquestionably one of the most controversial subjects in mental health law today. Voluntarily admitted patients have generally enjoyed such a right—at least in theory. Involuntarily committed patients' right to refuse treatment, particularly antipsychotic medication, has been quite another matter. Nonetheless, several courts have affirmed that even involuntarily committed patients have a constitutional right to refuse treatment in certain circumstances.

To call the debate one about the right to refuse medication is somewhat misleading, however. Until recently, there was no dispute that patients had a right to refuse treatment, including medication, as a corollary of the legal requirment of informed consent prior to treatment. The administration of treatment (even beneficial treatment) without consent is prohibited as unlawful assault and battery and punishable by criminal as well as civil penalties. The real question then is what is required to override a patient's refusal.

Most concede that the right to refuse medication can be overcome in emergencies involving imminent danger to physical health of the individual or others. Recent court decisions all recognize that forced medication must be permitted in certain emergencies, at least in institutions. But most courts have required that the decision to treat must be made by a qualified physician, less restrictive alternatives to medication must be demonstrably insufficient, and the primary purpose of the medication must be to mitigate a physical emergency, not merely to treat.[62] A further limitation is that the emergency must occur in an institution. While the courts have not yet ruled precisely whether someone living in the community may be forcibly medicated, language in some cases seems to indicate that they may not. For example, the Eighth Circuit Court of Appeals recently noted that "an individual who is not in full-time custody, care and treatment at a hospital cannot be forcibly medicated."[63] And in *Rennie v. Klein*, the Court of Appeals for the Third Circuit stated: "An

individual who has not been committed to a mental institution has a right to refuse medication sought to be administered against his will."[64]

The question then becomes under what circumstances may the patient's refusal be overridden in a nonemergency situation? Some federal courts have held, and the American Psychiatric Association has argued, that all that is required is exercise of a psychiatrist's professional judgment to override any patient's refusal.[65] Most courts, however, recognize that a threshold issue is the competence of the individual refusing medication.

Competence is a different legal concept from mental illness or committability; it means having the capacity to make decisions about health treatment. Most courts hold that a person who is competent has a right to make such decisions. Another key issue is, therefore, who decides whether or not a patient is competent. Advocates argue for judicial decision; states argue that doctors can make this decision, with or without the aid of "independent" hospital-based review boards. Some courts have held that if a patient is incompetent a hospital can go ahead and forcibly medicate;[66] others require that hospitals still go to court and that courts make a "substituted judgment" decision or a decision in the patient's best interests.[67]

The lower court in *Rogers v. Commissioner of Mental Health*, one of the first courts to consider this issue, held that incompetent patients, like others, cannot be medicated without consent except in emergencies.[68] It further held that only a patient's legal guardian can supply the necessary consent. The appellate court in *Rogers* and other courts have deferred more to attending clinicians. For example, in *Rennie v. Klein* the court would permit teams of clinicians, acting according to specified procedures, to override even guardians' decisions or to make their own decisions when it is difficult to obtain the guardian's consent.[69] The *Rennie* court carved out another exception to the general rule prohibiting forced medication. It held that a committed patient may be medicated against his or her will if "without [medication] the patient is incapable of participating in any treatment plan that will give him a realistic opportunity to improve his condition, or if it will shorten the required commitment time."[70]

Most courts have rejected such an exception. They reason that, except in an emergency, the sole justification for medication is to help the patient and, absent a finding of incompetence, all persons, including those involuntarily confined, have a right to decide whether and how they wish to be treated.[71]

A couple of recent cases illustrate these points. In cases decided less than one month apart, two federal appeals courts reached dramatically different conclusions. In *United States v. Charters*, the Fourth Circuit Court of Appeals upheld the right of a person found incompetent to stand trial to refuse psychotropic medication.[72] The court declared that refusal can only

be overridden in an emergency or when the patient has been found by a court to be incompetent to make decisions about medical care. The appeals court also reviewed the standard to be followed in the case of a person who is incompetent to make decisions about his or her medical care. It rejected a "professional-judgment standard," adopting instead a "substituted judgment standard." This standard provides that a determination must be made based on what the patient would have chosen if he were competent and, if that is not possible, what decision would be in his or her best interests. The question remains, however, whether this case applies to civilly committed individuals and whether the outcome would be different if "without medication a patient will suffer a severe, immediate and irreversible deterioration."

The Eighth Circuit Court of Appeals, in *Dautremont v. Broadlawns Hospital*, held that decisions to forcibly medicate a civilly committed patient must be the result of the exercise of professional judgment.[73] This court reasoned that although the patient's "liberty from bodily restraint, and therefore, arguably, mental restraint, survives involuntary commitment," the liberty interest was outweighed by the government's legitimate interests. Here, according to the court, the government's interests included returning the patient's behavior "to that which is acceptable to society and by the professionals' reasonable judgment here that the objective can best be accomplished by the administration of certain types and levels of psychotherapeutic drugs."[74]

The reasons to refuse medication considered most persuasive to courts continue to be religion and concerns about contracting tardive dyskinesia. Courts take both very seriously. In several jurisdictions a person with religious objections in entitled to a judicial hearing before being forcibly medicated, while the rights of people wih nonreligious objections are unresolved.[75]

In Indiana, for example, the supreme court, emphasizing a person's liberty interest in being free from intrusions into the body and mind, as well as the dangers associated with tardive dyskinesia, recently established standards to decide when a patient may refuse medication under an Indiana statute permitting a person to petition a court asserting a right to refuse medication.[76] In *In re M.P.* the court held that in order to override a patient's statutory right to refuse treatment, the state must demonstrate by clear and convincing evidence (1) that a current and individual medical assessment of the patient's condition has been made; (2) that it resulted in the honest judgment of the psychiatrist that medication would be of substantial benefit in treating the patient's condition, and not just a means of controlling the individual's behavior; and (3) that the probable benefits from the proposed treatment outweigh the risk of harm to, and personal concerns of, the patient. This court is the first to reject the possibility of

dangerousness as a justification for medicating a person without obtaining prior authorization from a court. The Indiana court also emphasized that forcible medication could not be ordered unless the court found it to be the least restrictive alternative, and that all forcible medication orders must be periodically reviewed and medication stopped if a patient did not substantially benefit from the treatment."

## Conclusion

The development of mental health law has been rapid. Courts have recognized new rights and, arguably, taken away others. For institutionalized individuals the exact parameters of the right to treatment and community placement and to refuse medication have begun to be clarified. Yet lack of resources as well as prejudice continues to prevent people with mental illness from being truly integrated into our society. In short, the issue of the rights and services to which people are entitled is likely to continue as a major battleground in the years ahead.

Yet, as the history of the development of mental health law shows, courts have the potential to become significant players in the effort to develop community care systems which provide decent conditions for people with mental illness. But it remains for ex-patients, consumers, family members, health care professionals, lawyers, and other advocates to work together to fulfill that potential. Surely one of the greatest challenges facing us all is to identify and implement strategies that will expand the availability of effective and quality community services and decent and low-cost housing. Failure to do so may result in either a return to the days of large custodial institutions or the reality of people left to live and die on the streets of our nation's cities.

ENDNOTES

1. Treffert, D., "Dying with Their Rights On" [Letter], 130 *American Journal of Psychiatry*, 1041 (1973).

2. Appelbaum, P., & Guthelil, T., "Rotting with Their Rights on: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients," 7 *Bulletin American Academy of Psychiatry and Law*, 308–317 (1979).

3. Ennis, B., *Prisoners of Psychiatry* (New York: Harcourt Brace Jovanovich, 1972).

4. Cordes, C., "A Step Back," *APA Monitor*, Apr., 1985, at 4.

5. *E.g.*, *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373, 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th

Cir. 1974); *New York State Association for Retarded Children v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975).

6. *E.g.*, *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972), *vacated*, 414 U.S. 473 (1974), *modified*, 379 F. Supp. 1376 (E. D. Wisc. 1974), *remanded*, 421 U.S. 957 (1975), *prior judg. reinstated*, 413 F. Supp. 1318 (E.D. Wisc. 1976). *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

7. *E.g.*, *Wyatt v. Aderholt*, 368 F. supp. 1382 (M.D. Ala. 1973) (state statute authorizing involuntary sterilization of mentally disabled women held unconstitutional). *See also* 42 C.F.R. §§ 50.201–50.210, which prohibit the use of federal funds for involuntary sterilization of mentally handicapped children or adults. *See also Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), and *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), *aff'd*, 720 F.2d 266 (3d Cir. 1983) (recognizing right to refuse medication in nonemergency situations).

8. *E.g.*, *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

9. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

10. *Rouse v. Cameron*, *supra*, 373 F.2d at 452–453.

11. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971).

12. *Wyatt v. Stickney*, *supra*, 325 F. Supp. at 784–785.

13. *Id.*

14. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

15. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

16. *Brewster v. Dukakis*, No. 7-76-4423-F (D. Mass. 1978), 675 F.2d 1 (1st Cir. 1982).

17. *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

18. After the *Brewster* decree was finalized, the state legislature refused to appropriate sufficient funds to carry out the decree and the court of appeals refused to compel the legislature to do so. *Brewster v. Dukakis*, 675 F.2d 1 (1st Cir. 1982). The *Brewster* decree then became the subject of political negotiation and the result is one of the nation's most successful community mental health programs.

19. At the time the lawsuit was filed, St. Elizabeths Hospital was owned by the federal government on land leased to it by the District. In November 1984, Congress passed legislation providing that by 1991 the hospital will be the sole responsibility of the District of Columbia government. Pub. L. 98-621, 98 Stat. 3369-3382.

20. In fact, funds allocated to inpatient care actually totaled more than $4.1 billion considering that funds for private and county hospitals were not included in the 70 percent figure. *See* Rubenstein, L., "Access to Treatment and Rehabilitation for Severely Mentally Ill Poor People," 20 *Clearinghouse Review*, 382–385 (Summer 1986).

21. *Id.*

22. The National Institute of Mental Health also estimates that of the 2.4 million people labeled chronically mentally ill, 1.5 million now live in the community. And of those, 110,000 people are in short-term treatment in hospitals, 290,000 live in halfway houses or group homes and 1.1 million live in private homes by themselves or with their families. Morgenthau, T., "Abandoned," *Newsweek*, Jan. 6, 1986.

23. Carling, P., *et al.*, *A Feasibility Study to Examine the Development of a Regional Community Mental Health System as an Alternative to Vermont State Hospital* (1985).

24. Two courts of appeals have held that institutionalized people have no constitutional right to placement in the community. *Society for Goodwill to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984), and *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). A recent Fourth Circuit decision, however, reached a different result. In *Thomas S. v. Morrow*, 781 F.2d 367 (4th Cir. 1986), the Fouth Circuit Court of Appeals upheld the right of a 20-year-old man diagnosed with schizophrenia and mental retardation and incapable of living independently to treatment in a community-based setting. Rejecting an inadequate-resources defense, the court held that money is simply not relevant in determining the scope of an individual's constitutional right.

25. *Arnold v. Sarn*, No. C432355 (Ariz. Super. Ct., Maricopa Cty. June 25, 1985).

26. *See Also Goebel v. City & County of Denver*, No. 81MH270 (Probate Ct., City & Cty. of Denver May 7, 1985) (court held lack of sufficient funds did not excuse defendants of their statutory duties to provide plaintiffs with care and treatment in the community).

27. *Arnold v. Arizona Department of Health Services, et al., appeal pending*, No. CV-87-0454-T (Ariz. Sup. Ct).

28. *Klosterman v. Cuomo*, 463 N.E. 2d 588 (N.Y. Ct. App. 1984), 481 N.E. 2d 580, 126 Misc. 2d 247 (N.Y. Sup. Ct., N.Y. Cty. Oct. 2, 1984). *See also Joanne S. v. Carey*, No. 18493/82 (N.Y. Sup. Ct., filed Aug. 10, 1982), a parallel case filed on behalf of the 140 patients of the Manhattan State Psychiatric Center who claim that they are unlawfully confined because there is no place in the community for them.

29. *Mental Health Association v. Deukmejian*, No. CA 000 540 (Cal. Super. Ct., Los Angeles Cty. Apr. 12, 1985).

30. For a compilation of such cases *see* Kanter, A., "Recent Zoning Cases Uphold Establishment of Group Homes for the Mentally Disabled," 18 *Clearinghouse Review* 515–518 (1984).

31. *Cleburne v. Cleburne Living Center*, 53 U.S.L.W. 5022 (U.S. July 1, 1985), 105 S.Ct. 3249 (1985).

32. *Cleburne v. Cleburne Living Center, supra*, 53 U.S.L.W. at 5026.

33. *Burstyn v. City of Miami Beach*, 633 F. Supp. 528 (S.D. Fla. 1987). Similarly, in *Sullivan v. City of Pittsburgh* 811 F.2d 171 (3d Cir. 1987), the city tried to close an alcoholism treatment center by refusing to issue the required conditional-use permits. The city argued that it made the decision on the basis of community opposition to the center. The federal court of appeals upheld the opening of the center, concluding that the opposition was motivated by prejudice against handicapped people and that the city "took its essentially unjustified action in an atmosphere charged with hostility toward a minority group."

34. *Pathways v. Ashland*, No. 87–82 (E.D. Ky. Dec. 17, 1987).

Other cases involving federal constitutional issues are:

*J.W. v. City of Tacoma*, 720 F.2d 1126 (9th Cir. 1983), in which the Ninth Circuit Court of Appeals held that the local zoning authority failed to pass a stringent test to prohibit mentally ill individuals from living together in a group home. The case involved eight individuals with histories of psychiatric hospitalization.

*Lieberman v. Board of Tax Review*, No. CV 850076085 (Conn. Super. Ct. May 14, 1987), in which a group of property owners in Greenwich, Connecticut, who were unsuccessful in preventing the opening of a group home for mentally ill adults in their neighborhood petitioned the tax review board to lower assessments on their homes. The tax board agreed to lower assessments, based solely on the neighbors' fear that the presence of the home justified the reduction. Connecticut's attorney general, Sen. Lowell P. Weicker, Jr. (as a Greenwich taxpayer), and Mental Health Law Project (on behalf of an

association of group home operators) filed suit against the tax review board, charging that its decision was motivated solely by prejudice and fear. The case was settled with the town agreeing not to use the existence of the group home as a factor in calculating the assessments.

*People v. 11 Cornwell Company*, 695 F.2d 34 (2d Cir. 1982), in which a group of neighbors in a suburb of New York City, upon hearing that a group home was planned, bought the property on which the home was to be located. The state sued the property owners on the grounds that their action violated the civil rights of the prospective residents and the New York human rights law. The Second Circuit Court of Appeals agreed.

35. Currently, about one-third of the states have adopted standards for civil commitment providing that only people who are mentally ill and dangerous may be committed. The remaining states have a less stringent standard, providing commitment of those who are "gravely disabled." For the most up-to-date compilation of state commitment laws, *see* pp. 33–46 in Brakel, S., et al., *The Mentally Disabled and the Law* (Chicago: 1986).

36. Perkins, J., "New Institution for the Homeless," *Wall Street Journal*, Feb. 26, 1985.

37. Lamb, H. R. (ed.), *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association* (Washington, DC: American Psychiatric Association Press, 1984).

38. Dunham, A., "APA's Model Law: Protecting the Patient's Ultimate Interests," 36 *Hospital and Community Psychiatry* 973, 974 (September 1985).

39. *See* Borus, J., "Deinstitutionalization of the Chronically Mentally Ill," 305 *New England Journal of Medicine*, 339 (1981); Feldman, S., "Out of the Hospital, onto the Streets: The Overselling of Benevolence," 13 *Hastings Center Report* 5 (1983).

40. *See* Holden, C., "Broader Commitment Law Sought," 230 *Science* 1253 (1985).

41. Goldman, H., et al., "The Multiple Functions of the State Hospital," 140 *American Journal of Psychiatry* 296 (1983).

42. In 1981 more than 370,000 people were admitted to state mental hosptials, the vast majority of whom were released within two months (the acute care patient). United States Department of Health and Human Services, National Institute of Mental Health, *Mental Health United States, 1985*, Tables 2.3 and 2.8.

43. Craig, T., & Laska, E., "Deinstitutionalization and the Survival of the State Hospital," 34 *Hospital and Community Psychiatry* 616 (1983); Weinstein, A., & Cohen, M., "Young Chronic Patients and Changes in State Hospital Populations," 35 *Hospital and Community Psychiatry* 595 (1984).

44. Rubenstein, L., "APA's Model law: Hurting the People It Seeks to Help," 36 *Hospital and Community Psychiatry* 968, 970 (1985).

45. The median length of stay in state and county mental hospitals is 23 days with people diagnosed with schizophrenia remaining the longest (42 days) and alcohol and substance abusers remaining the shortest (12 days). United States Department of Health and Human Services, National Institute of Mental Health, *Mental Health United States, 1985*, Table 2.17.

46. *See, e.g.*, Goldman & Shore, "Beyond Deinstitutionalization," 311 *New England Journal of Medicine* 832 (1984).

47. "Outpatient commitment" is not a single procedure but encompasses three very different approaches to compulsory community care. First, it refers to the process by which an individual who no longer satisfies the standard for inpatient commitment may be required to obtain community treatment. This procedure is also known as "conditional release." "Outpatient commitment" may also mean involuntary community treatment imposed as a dispositional alternative by a court in a commitment

hearing, requiring the client to receive community treatment as a less restrictive alternative to inpatient hospitalization. And finally, in its most recent form, it authorizes a court to order an individual who does not meet the standards for commitment to receive treatment on an outpatient basis.

48. For an analysis of these laws, *see* Stefan, S., "Preventive Commitment: The Concept and Its Pitfalls," 2 *Mental & Physical Disability Law Reporter* 288–302 (July–August 1987). *See also* Owen, J., *Involuntary Outpatient Commitment: An Explanation of the Issues and Its Utilization in Five States* (Washington, DC: National Institute of Mental Health, November 1985).

49. Stefan, S., "Preventive Commitment: The Concept and Its Pitfalls," 2 *Mental & Physical Disability Law Reporter* 288–302 (July–August 1987).

50. *See* Hiday & Goodman, "The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness," *Journal of Psychiatry and the Law* 81 (Spring 1982).

51. *Ingraham v. Wright*, 430 U.S. 651, 672–673 (1977).

52. *Union Pacific Railway v. Botsford*, 141 U.S. 250, 251 (1891); *see Faretta v. California*, 422 U.S. 806, 834 (1975); *Roe v. Wade*, 410 U.S. 113 (1973).

53. *See O'Connor v. Donaldson*, 422 U.S. 563, 583 (Burger, C.J. concurring).

54. *See generally*, Tribe, L., *American Constitutional Law* at 896 (1978).

55. *Jackson v. Massachusetts*, 197 U.S. 11 (1905).

56. *State v. Also*, 11 Ariz. App. 227, 230, 463 P.2d 122, 125 (1969).

57. *Schuringe v. City of Chicago*, 198 N.E. 2d 326, 333–334, *cert. denied*, 379 U.S. 964 (1965).

58. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *see also Addington v. Texas*, 441 U.S. 418, 425 (1979).

59. The policy takes effect whenever the Health Department declares a cold weather emergency, which is defined as the time the temperature drops below 32°F, between 4 P.M. and 8 A.M. Philadelphia enacted a similar directive the following year. In New York, the patrol officers must make the initial judgment that a person is homeless and incompetent to care for him- or herself in cold weather. They must then request that a sergeant from their precinct concur in their evaluation. If so, they are required to transport the homeless person involuntarily to a "Health and Hospital Corporation emergency room for medical and psychiatric evaluation and, if appropriate, admission."

60. Coleman, "To Expert Eyes City Streets Are Open Mental Wards," *New York Times*, Nov. 4, 1986, at B1, col. 1; Coleman, "For Mentally Ill in the Streets a New Approach Shines," *New York Times*, Nov. 11, 1986, at C1, col. 1; Hevesi, "Homeless in the City: A Day on the Streets," *New York Times*, Nov. 17, 1986, at B1, col. 1; Shifren-Levine, I., et al., "Community Support Systems for the Homeless Mentally Ill," *New Directions: The Homeless Mentally Ill* (E. Bassuk, ed.; Boston: 1986); Coleman, "Diary of a Homeless Man," *New York Magazine*, Feb. 21, 1983, at 15, 27.

61. *Boggs v. New York City Health and Hospitals Corp.*, 523 N.Y.S. 2d 71 (N.Y. App. Div. 1987).

62. *See Rennie v. Klein*, 653 F. 2d 836, 846–848 (3d. Cir. 1981) and *Rogers v. Okin*, 634 F.2d 650, 656 (1st. Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 102 S.Ct. 2442 (1982).

63. *Lappe v. Loeffelholz*, 815 F.2d 1173, 1179 (8th Cir. 1987).

64. *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981).

65. *Dautremont v. Broadlawns*, No. 86-1977 (8th Cir. Aug. 20, 1987).

66. *Riese v. St. Mary's*, No. A03 4048 (Cal. Ct. App. Dec. 16, 1987), *appeal pending*, No. S004002 (Cal. 1988); *In re K.K.B.*, 609 P.2d 748 (Okla. 1980).

67. *Rogers v. Commissioner of Mental Health*, 458 N.E.2d 501 (Mass. 1983); *People v. Medina* 705 P.2d 961 (Colo. 1985).

68. *Rogers v. Commissioner of Mental Health*, 458 N.E.2d 501 (Mass. 1983).

69. *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981).

70. *Rennie v. Klein*, *supra*, 653 F.2d at 848.

71. *See, e.g., Davis v. Hubbard*, 506 F.Supp. 915, 931 (N.D.Ohio 1980), and *In re K.K.B.* 609 P.2d 747, 750 (Okla. 1980).

72. *United States v. Charters*, 829 F.2d 479 (4th Cir. 1987), *reh'g granted en banc*, May 2, 1988.

73. *Dautremont v. Broadlawns*, No. 86-1977 (8th Cir. Aug. 20, 1987).

74. *Dautremont v. Broadlawns*, No. 86-1977, slip op. at 6 (8th Cir. Aug. 20. 1987).

75. *See e.g. In re Milton*, 505 N.E.2d 255 (Ohio 1987) and *In re Bryant*, No. MH-1428-85 (D.C. Ct. App. Mar. 25, 1988).

76. *In re M.P.*, 510 N.E. 2d 645, 647 (Ind. 1987).

77. Other cases involving refusing medication recently decided by the highest courts of their states include: *Henderson v. Yokum*, No. 79-48A (1st Jud. Cir., S.D. Feb. 19, 1987), which upheld the right to refuse treatment reasoning that use of medication involves invasion of physical and mental liberty interests; *Jarvis v. Levine*, No. C2-86-1633 (Minn. Jan. 15, 1988), which requires a judicial determination of incompetence prior to forcible medication; *State ex rel. Jones v. Gerhardstein*, 416 N.W. 2d 883 (Wisc. 1987), which held that the provision of judicial review of treatment refusal to precommitment detainees but not to committed patients violated the state constitution's equal protection clause; and in the latest round of *Keyhea v. Rushen*, No. 67432 (Cal. Sup. Ct., Solano Cty. Oct. 31, 1986), the lower court detailed extensive procedural requirements before the state could medicate prisoners against their will.

# Model Programs for Persons with Chronic Mental Illness: An Overview of the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill*

Martin D. Cohen, *Robert Wood Johnson Foundation Program for the Chronically Mental Ill*

## Introduction

The Program for the Chronically Mentally Ill is a national demonstration project sponsored by the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development (HUD). Over a five-year period, the program is establishing comprehensive systems of care, including rehabilitation and housing, for people who suffer from serious mental illness in 9 of the nation's 60 largest cities. These 9 cities are Austin, Texas; Baltimore, Maryland; Charlotte, North Carolina; Cincinnati, Ohio; Columbus, Ohio; Denver, Colorado; Honolulu, Hawaii; Philadelphia, Pennsylvania; and Toledo, Ohio.

The new systems of care being developed under the program will offer a broad range of medical, mental health, vocational, and housing services designed to help people with serious mental illness function more effectively in their everyday lives.

The Robert Wood Johnson Foundation is providing approximately $28 million in grants and low interest loans to support projects in these cities that consolidate and expand services for people with serious mental illness. HUD is providing 125 Section 8 rent subsidies per city to assist grantees in developing safe, affordable housing in their communities.

The program is cosponsored by the National Governors' Association, the U.S. Conference of Mayors, and the National Association of Counties. Together, the cosponsors represent the combined perspectives of city, county, and state governments—all the jurisdictions needed to help build a complete service system.

## Background

The past 25 years have seen profound change in the care of people with serious mental illness. A dramatic illustration of this change is the decrease in the number of patients residing in public mental hospitals, from

*The views expressed in this paper are those of the author. No endorsement of the Robert Wood Johnson Foundation is intended or should be inferred.

approximately 560,000 in 1955 to about 120,000 in 1980—a decrease of 75 percent (Clarke, 1979). Over the same period the number of people who suffer from serious mental illness has grown from an estimated 1.5 million to 2.4 million (Goldman & Manderscheid, 1987).

Deinstitutionalization is largely viewed as having failed this population, because communities have been unprepared to offer continuing inpatient and outpatient care for the chronically mentally ill, or to help them adjust to a community setting after living in institutions for many years. Most important, community mental health centers have lacked programs that meet the basic needs of this population—such essentials as food, clothing, shelter, and medical care in addition to transportation, employment, and recreation.

Widespread recognition of the shortcomings of care for the chronically mentally ill has led to a number of major studies by government and professional groups. Emerging from these efforts is a consensus that while the rationale for deinstitutionalization is a sound one, its implementation has been flawed.

Exemplary programs now demonstrate that it is feasible to provide care in community settings for most patients who in years past would have resided in public mental hospitals (Stein & Test, 1980; Gudeman & Shore, 1984). Most of these successful community-based programs share the following elements:

- a comprehensive range of support services available in varied settings as alternatives to institutional care;
- assignment of clear and consistent responsibility for all seriously mentally ill people; and
- budgetary control over the broad range of relevant services and settings, with fiscal incentives for providing appropriate and cost-effective care.

Major cities face special challenges in developing the full range of community-based services—including housing—needed for this population. In most large cities there is a growing shortage of low-rent housing resulting from condominium conversion, demolition, or arson. Research has established that large cities attract a disproportionate share of chronically mentally ill persons. Many of these are young persons with no previous history of contact with mental health programs who are resistant to participation in treatment. In most communities the fragmented organization and financing of such services prevents the development of coordinated programs in the community which are needed to prevent both institutionalization and homelessness. Services are often the responsibility of different departments of local, county, or state governments, with little or no coordination or connection among these agencies.

A striking example is found in the development of supervised housing for mentally ill persons, which requires collaboration by the public housing

authority, usually a local or county government unit, and the community mental health center, which is a state or county program. Relationships among public housing authorities and mental health agencies are typically informal, without the established procedures by which a mental health agency can rely upon the resources of the housing authority to find, produce, finance, and manage housing for the chronically mentally ill.

Adding to the fragmentation between and among government units is the structural disorganization created by the establishment of catchment areas for mental health services in the late 1960s. Most large cities have multiple community mental health centers, each serving a catchment area of 75,000 to 200,000 people. In very few cases is there one catchment area or community mental health center which encompasses the entire city. Catchment area boundaries rarely follow traditional neighborhood lines, police districts, or other recognized boundaries. Not only do these community mental health centers lack formal ties to one another, but they also fail to articulate with other social systems (e.g., welfare, social services, vocational rehabilitation systems) necessary for chronically mentally ill persons to maintain themselves in the community. Often, these other social support systems are organized citywide and therefore must interact with multiple mental health centers, resulting in confusion for both staff and patients.

This fragmentation and disorganization often result in community mental health systems that fail to provide the chronic patient with continuity of care. Although support services, financial entitlements, inpatient and outpatient care, and case management may be available to the patient, they are delivered by multiple providers. Without formal linkages between and among providers care is uncoordinated, and patients, families, and caregivers themselves are confused and demoralized.

A potential solution to these problems lies in the reorganization of urban mental health services under a central authority combining administrative, fiscal, and clinical responsibility for all services to chronically mentally ill persons within the urban area. To be effective, such an authority must retain accountability to state and local governments while being freed administratively to take advantage of the flexibility of the private sector. It is this type of authority that is being demonstrated under the Robert Wood Johnson Foundation's Program for the Chronically Mentally Ill.

## Program Goal

The Program for the Chronically Mentally Ill seeks to build on this experience to enable people with serious mental illness to live independently. Toward that end, the program is funding a wide variety of support services and housing alternatives, managed under a single organization.

To achieve this goal, the program has identified five key elements to be tested in the nine demonstration sites:

Central Authority:
A single point of clinical, administrative, and fiscal responsibility.

Continuity of Care:
A designated care-giver for each client, responsible for coordinating the various components of the service system to meet the client's needs.

Financing Reform:
A flexible financing system in which dollars can be moved to meet clients' needs.

Housing:
The development of a range of housing options for the chronically mentally ill.

Range of Services:
A range of psychosocial and vocational rehabilitation programs that support clients in the community.

*Central Authority*

The central mental health authority concept is taking many forms among the nine grantee sites. In some cities it is an existing county mental health board, and in others new private/nonprofit corporations are being established to deliver services. In Denver, Colorado, the city and state have worked collaboratively to create the Denver Mental Health Corporation, a nonprofit agency which will coordinate the allocation of funds to the four community mental health centers serving the Denver area, as well as psychiatric services provided by the Denver Health and Hospital system. In addition, the authority will serve as the organizational entity responsible for housing for the chronically mentally ill, and will have clinical oversight over all services delivered in the Denver area. (See Figure 1.) In Austin, Texas, the existing county mental health agency will broaden its responsibility to serve as a central mental health authority.

The central authority concept also brings increased flexibility to the management of public mental health services. In Honolulu, Governor John Waihee has chosen to use the Foundation grant as a vehicle for improving the coordination of services to chronically mentally ill persons by state government. The Hawaii plan calls for the state to develop a cabinet cluster within the governor's office to coordinate those state departments which provide services needed by chronically mentally ill persons. The new cluster, to be known as the Governor's Cabinet Subcommittee on Adult Mental Illness, will serve as a governing board for bringing together

services provided by the Departments of Health, Human Services, Labor, and Housing and Community Development. Operational responsibility will be vested in a newly reorganized Division of Mental Health within the Department of Health. (See Figure 2.) This flexibility and Organizational freedom is designed to support changing patterns of service delivery and to foster innovation within public mental health systems.

Figure 1. Central Authority: Denver.

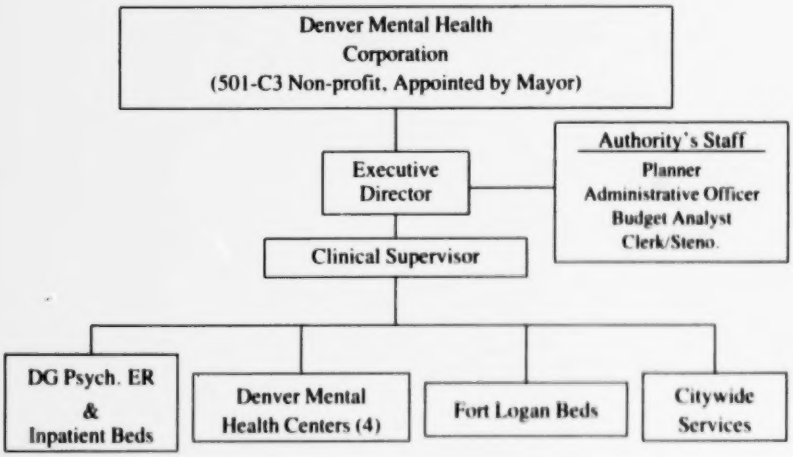
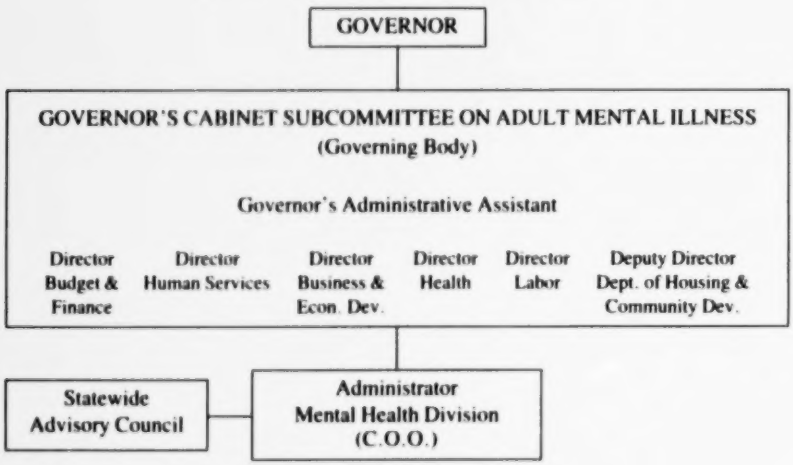



Figure 2. Central Authority: Hawaii.



*Continuity of Care*

Continuity of care has been stressed as a basic organizing principle for new service systems. The nature of chronic mental illness, characterized by periods of relative stability interspersed with acute psychiatric episodes, requires attention to the unique relationship between the individual and the provider system. The concept of a continuous care-giver means that each person served by the system has a staff member identified as responsible for his or her care. In most cases, this staff member is a case manager, but could also be a primary therapist or an individual who is part of a treatment team. The concept of continuity of care is being implemented in a variety of ways in each of the grant sites.

In Columbus, Ohio, the Franklin County Mental Health Board has developed continuous treatment teams as a way of providing continuity of care to the chronically mentally ill. Each team is composed of five people at a minimum and includes one qualified mental health professional, a licensed registered nurse, and three case managers. In addition, the team has access to psychiatric backup. The five team members provide services to an assigned caseload of no more than 30 clients each or 150 clients per team. The teams meet daily for service-planning and -monitoring purposes. The teams provide assistance in performance of daily living functions, vocational services, and health services.

In Maryland, Baltimore Mental Health Systems (BMHS), in conjunction with Johns Hopkins University, is developing a new Clinical Information System (CIS) to support the treatment and care of persons served by mental health agencies in the Baltimore area. The CIS system will provide up-to-date information on program enrollment, treatment, and units of service provided to individual clients to assist clinical staff in patient care; provide mechanisms to alert clinical staff to events requiring follow-up (e.g., discharge of a person from the state hospital to the community, emergency room contact, possible breaks in service due to nonattendance, etc.); and provide a data base for ongoing monitoring and evaluation of the effectiveness of the BMHS.

A major strength of the BMHS will be the integration of all major service providers into a common data network. While issues of client confidentiality will need to be considered carefully, the new system could provide an excellent way of tracking clients as they move through the area mental health programs.

*Financing Reform*

The Program for the Chronically Mentally Ill has been working closely with the program sites, the Health Care Financing Administration, and state agencies to bring new ideas to the financing of mental health services

to improve their efficiency, quality, and cost-effectiveness. Several sites are preparing capitated payment plans aimed specifically at Medicaid beneficiaries, while other sites will attempt to consolidate state, county, city, and Medicaid financing streams in order to improve the management of scarce resources. In Philadelphia, Pennsylvania, the Office of Mental Health and Mental Retardation is developing a managed care agency which will prescreen all mental health benefits provided to Medicaid recipients. In addition, the city plans to develop a capitated payment system which will provide incentives for public and private agencies to serve seriously mentally ill persons.

*Housing*

Housing for the chronically mentally ill and the homeless mentally ill is a growing national problem. Under the Program for the Chronically Mentally Ill each grantee will develop a housing plan for the development of 300 to 500 new units of housing. The Department of Housing and Urban Development will support this effort through the allocation of 125 Section 8 housing certificates to each community. Low-interest loans of up to $1 million each will be available from the Foundation to acquire and renovate housing specifically for this population. Each grantee is using the loan fund to leverage private housing development resources such as community block grants, commercial loans, and bond financing which may be available in each community. To assist each site in the development of effective housing plans, the Foundation has contracted with American City Corporation, a subsidiary of the Rouse Company, Columbia, Maryland, to provide training and technical assistance. The technical assistance is designed to promote the mental health authority's understanding of the housing development process, assist in financial feasibility, and develop strategies for leveraging private development funds. The goal is to create an entrepreneurial perspective within mental health agencies to satisfy the housing needs of their patients.

*Full Range of Services*

The second major goal of the Johnson initiative is to create a full range of services for the chronic patient. The program will provide funds to initiate or expand within each local community such services as residential facilities, day treatment and rehabilitation programs, supported and transitional employment, and varieties of case management and outreach to underserved groups. Many of the project sites have already established supported employment programs as a vehicle to help chronically mentally ill persons become productive wage earners. In Cincinnati, Ohio, the Hamilton County Mental Health Board will develop a continuum of

vocational services, thus giving the patient a variety of vocational avenues from which to choose.

## Progress in the Demonstration Sites

The nine demonstration sites are creating systems of care that provide flexibility in the management and operation of mental health systems, that are accountable to the public, and above all that meet the needs of the clients they are designed to serve. The following is an overview of major progress achieved in each city to date.

### *Austin, Texas*

The Austin–Travis Mental Health/Mental Retardation Center is concentrating its efforts in three areas: community support services, housing, and interagency coordination. New community support services include a client drop-in center, a partial hospitalization program, expansion of vocational programs to include supported employment, a training program for community living skills under the Fairweather Lodge model, and a homeless outreach program.

Austin is also developing 300 apartment units over the next two years. The Austin housing plan relies on a $5.5 million line of credit from a local bank, 125 Section 8 housing certificates, and owner financing.

Improvements in accessing other service systems are occurring through the work of a community liaison specialist who is working with local health and human service agencies to provide training and education about the special needs of people with serious mental illness.

### *Baltimore, Maryland*

A not-for-profit corporation, Baltimore Mental Health Systems, Inc., has been established to restructure and consolidate city mental health services. Among the activities of this organization is the development of a case management unit to serve mentally ill persons who are also homeless and/or discharged from the city jail. Two mobile psychiatric units offer outreach, case management, medication, and psychiatric services to clients identified as frequent users of hospital psychiatric services. Expansion of supportive employment services is also planned.

Baltimore Mental Health Systems will also assume responsibility for the management of all community mental health contracts from the Baltimore City Health Department. A financial advisory committee representing state, federal, and private organizations is developing methods for maximizing Medicaid reimbursements for mental health services. In addition, the program is developing a comprehensive client management informa-

tion system which will link all existing mental health agencies into a common client data base.

The Baltimore housing plan calls for lease and purchase of 375 housing units, serving 500 people primarily in apartments and group homes. Financing will be through a combination of federal, state, and private funds.

*Charlotte, North Carolina*

The Mecklenburg County Area Mental Health Authority is designated as the administrative, clinical, and financial authority for all services to the seriously mentally ill in Charlotte. The Authority has improved coordination with other county-funded social services by developing an automated client tracking system.

Four case management teams have been hired with grant funds to provide all primary support services to clients living in the community. Each team, consisting of five mental health professionals with varying specialities and a supervisor, serves 220 seriously mentally ill clients.

Mecklenburg County plans to provide housing for 303 clients in 200 apartment units over the next four years. The Community Housing Development Corporation was formed to purchase and manage one-, two-, and three-bedroom units scattered throughout the county. Financing will be obtained through conventional mortgages and government rehabilitation loans.

*Cincinnati, Ohio*

The Hamilton County Mental Health Board is developing a managed care system, which will unify all services in Cincinnati by consolidating administrative, clinical, and fiscal authority in the Board.

As part of the community planning process, the Board has set up an advisory committee of human service agencies and community leaders. The committee will recommend improvements in the county mental health system for people with serious mental illness.

A consortium of day services, ranging from social clubs to supported employment, is being developed in Cincinnati. The consortium involves several state and community agencies in a long-range plan to offer day services.

Cincinnati's housing plan calls for the development of 485 units combining single-room-occupancy and one-, two-, and three-bedroom apartment units over a 10-year period. A nonprofit housing corporation, Excel Development Corporation, has been formed to acquire and manage these properties. Long-term financing will come from local tax levy funds, state funds, and private investments.

*Columbus, Ohio*

The Franklin County Mental Health Board has created the Office of Community Treatment to plan and coordinate the new system of care. Five mobile treatment teams, consisting of nurses, social workers, and other mental health professionals, will provide support services required to keep clients in the community. Each team is responsible for the care of 150 clients. Three teams offer general support, as well as specialized intensive support for homeless persons and those with substance abuse problems. Seven more teams will be added over the next year.

The Franklin County Mental Health Board has also designed a new allocation and contracting process which strengthens its relationship with its service providers. This new system will focus resources on those clients with serious mental illness.

Expansion of vocational services includes a new supported employment program which will place clients in permanent jobs. The county is also the site for a Federal Social Security demonstration which will examine ways to assist people in finding permanent employment and to identify predictors of work success.

A separate nonprofit housing development corporation, Community Housing Network, has been established to acquire, renovate, and manage 310 housing units for 496 residents, who will receive support services from the community treatment teams.

*Denver, Colorado*

Denver's major accomplishment is the development of a nonprofit corporation, the Mental Health Corporation of Denver, to serve as a central authority for all mental health services in the City of Denver and Denver County. The Corporation has clinical, administrative, and fiscal responsibility for services which historically have been provided by multiple organizations including private community mental health centers, specialty clinics, and city and state hospitals. The Mental Health Corporation of Denver provides a new administrative structure in which the activities of these organizations can be better coordinated. The ultimate goal will be better planning, resource allocation, and clinical oversight.

In addition to managing existing services, the grant has allowed Denver to expand citywide services to include outreach to homeless persons and the establishment of case management for the most seriously mentally ill referred from shelters, jails, and hospital emergency rooms. Since February 1987 the program has served over 800 clients. In addition, the program has developed a jail diversion program which provides intensive services so that over 100 mentally ill persons can be diverted from inappropriate jail placements to more appropriate mental health services.

Denver's housing plan, making use of new and existing housing resources, calls for purchase of 225 units of scattered-site housing, primarily through acquisition of one- and two-bedroom houses throughout the city and county. The Mental Health Corporation will use an existing housing development corporation with 14 years of experience to develop these units.

*Honolulu, Hawaii*

Grant activities are being coordinated by the Hawaii Department of Health's Division of Mental Health. The focus has been on four areas—the creation of a cabinet-level mental health authority, development of a case management system with a single point of entry, improvement of psychiatric treatment, and design of a client-tracking system and data base.

The governor's Cabinet Subcommittee on Adult Mental Illness has been established to consolidate fragmented statewide services for people with serious mental illness. This group, comprising the state directors of labor, housing, economic development, budget and finance, health, and human services, meets regularly as a policy and coordinating body, bringing together all the state and city agencies that serve people with serious mental illness.

The Division of Mental Health has initiated a case management system which will create a more accountable and coordinated service system. Case management teams will coordinate client assessments, service plans, and services which are overseen by those agencies represented on the governor's subcommittee.

Other initiatives being developed under the grant include improved training of psychiatric residents at the University of Hawaii and development of a model social club that can be used as a training environment for new staff members.

*Philadelphia, Pennsylvania*

The Philadelphia Mental Health Program is initiating financing reform to direct mental health dollars to those most in need. The program has analyzed over 30 months of Medicaid-paid claims in anticipation of developing capitation plans under a Medicaid waiver option. Once accomplished, this financing reform will affect services to 2,500 clients.

Four program support teams have been hired to provide outreach and continuity of care to 80 seriously mentally ill people coming out of state hospitals. In addition, the Office of Mental Health and Mental Retardation will consolidate five existing adminstrative case-monitoring projects under the management of the Philadelphia Mental Health Program, thus providing an immediate capacity to provide managed care to 1,500 clients who are heavy users of psychiatric emergency and inpatient services.

Philadelphia's housing plan calls for the development of mixed-density rental units, including scattered-site apartments and single-room-occupancy/efficiency units, as well as the purchase of two- and three-bedroom row houses.

*Toledo, Ohio*

The Lucas County Mental Health Board has developed three new support services. The Community Based Stabilization Program offers crisis support for clients in their own homes through a team of mental health professionals. Since the program began in November 1987, it has served 130 people, frequently preventing rehospitalization.

A total of 25 intensive case managers are based at two cooperating mental health centers, with each manager serving 15 to 20 clients. This new program is proving to be an essential component in the support network being established for people with serious mental illness.

A new supportive employment program is helping clients to find permanent work in their communities. Job coaches help clients look for jobs and work with employers to ensure that problems are worked out.

Toledo's housing plan calls for the development of 384 units in one-, two-, and three-bedroom apartments scattered across Lucas County. A total of 250 units will be reserved for 372 people with serious mental illness, and the remainder of the units will go to qualified low-income residents. This approach will create apartment settings which minimize the stigma associated with housing exclusively for the mentally ill.

## Evaluation of the Program

As a national demonstration the Program for the Chronically Mentally Ill has the opportunity to provide insight into a wide range of policy issues on mental health care and homelessness. To realize this potential, the Foundation has formed a partnership with several federal agencies to fund an independent scientific evaluation of the implementation and effectiveness of this initiative. Under contract with the Foundation and the National Institute of Mental Health, the University of Maryland Center for Mental Health Policy Studies is conducting an examination of the organizational, political, and financial dimensions of the Program. It will also be conducting a study of client outcomes in selected demonstration sites.

## Elements of Success

In the year and a half that the Johnson initiative has been under way, several key factors have been identified as important to a successful unified system of care.

*Leadership*

Effective leadership at both the project and community level is essential for program success. In those cities where community leaders have embraced the concepts of the RWJ initiative, progress is more defined and tangible. This is in contrast to those cities where there has been discontinuity in the leadership of the mental health authority, be it state or county. In those cities where systemwide changes are required, leaders must be able to transcend common organizational boundaries and articulate program goals to the large community.

*Unified Advocacy*

Systems change requires that there be unified advocacy for and involvement in the change process. Families, consumers, professionals, community groups, and labor leaders must be ready to come together to talk about common issues and problems. Resistance to change has been overcome in several cities by drawing attention away from guild issues and toward patient needs. In many cities, unified advocacy has resulted in increased public awareness of the needs of the mentally ill and strategies for wider community acceptance and funding for services to the chronically mentally ill.

*Willingness to Take Risks*

Successful demonstration sites are also distinguished by their willingness to be creative and take a certain amount of risk in the redesign of their mental health systems. Very often this means a willingness to move away from traditional program models and experiment with new service initiatives such as continuous treatment teams and client-operated services. Such risk taking also includes a willingness to examine closely traditional service systems and consolidate or reallocate existing resources to meet patient needs better.

## Summary

The Robert Wood Johnson Foundation Program for the Chronically Mentally Ill offers a unique opportunity to test the efficacy of new systems of care for the chronically mentally ill in our nation's largest cities. This opportunity brings with it new challenges for mental health administrators and clinicians. It is hoped that the results of this demonstration, both in content and process, will serve other cities as they strive to make mental health services more accessible and more effective for those most in need.

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# Estimates of Need for Mental Health Services in Texas Counties

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## Introduction

A continuing legacy of the Community Mental Health Centers movement of the early 1960s has been the goal of providing improved care and treatment for the mentally ill within their communities of origin. An important part of the effort to develop community-based services has been the assessment of mental health needs in general populations. "Needs assessment" is defined as the process of estimating numbers of mentally ill persons in a given population and then comparing these estimates to the proportion receiving services from existing programs. This information can be used to evaluate programs and often to document the inadequacy of given levels of resources. Some sort of needs assessment must be conducted if legislatures are to be persuaded to increase public spending for mental health services. Based on mental health needs assessment, planning efforts can focus on "unmet need for services"—on those mentally ill persons who are receiving no services, inadequate services, or inappropriate services.

Although the potential value of needs assessment activities has been recognized, a number of barriers stand in the way of achieving this potential. These include the following:

- ☐ Lack of adequate definitions of mental health need
- ☐ Inadequate methodologies for assessing need
- ☐ High cost of implementing needs assessment programs
- ☐ Pessimism about availability of resources to meet known demand

This paper presents the results of a needs assessment project conducted by the authors with collaboration and support from the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the National Institute of Mental Health (NIMH). This project had two major parts. First,

we developed specific operational definitions of need for mental health services, corresponding to state agency priorities. Second, based on those definitions, we attempted to estimate and project specific levels of need for mental health services in all Texas counties. The estimates were generated through an indirect statistical procedure which applies psychiatric risk models to the demographic profile of each county.

## Definitions of Need for Mental Health Services

The term "need for mental health services" implies much about program planning but little about specific disorders or dysfunctional conditions that could benefit from intervention. Ideally, "need for service" corresponds to the presence of any psychiatric illness of sufficient severity that treatment is required and for which an accepted diagnosis and treatment exists. Needs assessment would be simpler and more rational if "need" meant any disorder in the DSM-III-R, and if a specific, efficacious, and accepted intervention existed for each disorder. Unfortunately, mental health professionals still disagree about how (and even whether) to treat particular disorders, and not about the DSM-III-R diagnostic criteria themselves. Further, there are many potential psychiatric clients who never seek treatment, even for some major disorders. Perhaps more importantly, public resources for mental health services are limited. Consequently, priorities must be established for determining which sorts of mental health conditions and needs must be served with limited public funds.

The focus of this conference on the "chronically mentally ill" (CMI) reflects a high priority assigned to long-term, major mental health problems. Significantly, the goals and concerns of this conference demonstrate that progress has been made in identifying service priorities. The term CMI and the related one "seriously mentally ill" (SMI) generally refer to persons with mental disabilities that are both severely incapacitating and chronic in course, perhaps most typified by schizophrenia. Most definitions of CMI or SMI are based on the presence of a serious psychiatric illness such as schizophrenia or major affective disorder and also specify some degree of functional impairment associated with long-term illness. At the other end of the scale are DSM-III disorders that are less serious, or associated with little or no long-term impairment, such as anxiety disorders or phobias. For discussion of the prevalence of DSM-III disorders in the community, see Myers et al. (1984).

### *Texas Definitions of Priority Service Populations*

Most state mental health planning agencies have formalized definitions of the populations which are to receive the highest priority in planning and funding efforts. The state of Texas has a set of formal criteria for

classifying mental health service groups into various "priority populations." These definitions were developed in the last decade as a policy guideline, giving greater priority to services for those who are the most seriously ill, who have chronic disorder, and who exhibit either dangerousness or dependence due to the impairment of normal functioning. Table 1 summarizes the criteria designated by the state of Texas for the five "priority population service groups" and one "nonpriority population service group." Group I has highest priority and Group VI the lowest.

The goal of our research project was to estimate the numbers of people who meet these official criteria in each county, region, and local service area in Texas. An additional goal was to examine the effects of specific criteria, and alternative operational definitions thereof, in determining the estimated size of each priority service population. This was accomplished in several steps. First, the criteria were operationally measured using existing data from a large survey of psychiatric disorder in the community,

Table 1

Texas Definition of Priority Populations

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I. Chronically dyfunctional mental disorder, with present dangerousness and/or dependency. This requires at least two years of duration (or six months if a child).

II. Historically dysfunctional mental disorder, with present dangerousness and/or dependency. This requires mental disorder of less than two years' duration with present dangerousness and/or dependency and either:
   - at least one previous psychiatric hospitalization; *or*
   - at least one involuntary commitment to psychiatric services.

III. Primary commitment: A person with dangerousness and/or dependency who has a current, first-time court commitment (including emergency detention and orders of protective custody) to psychiatric services.

IV. Chronically dysfunctional mental disorder, with threat of deterioration to dangerousness and/or dependency. This requires two years' duration and a threat of deterioration to dangerousness and/or dependency.

V. Dysfunctional mental disorder, with threat of deterioration to dangerousness and/or dependency.

VI. All other persons receiving mental health services. This category (nonpriority) includes:
   - Dysfunctional mental disorder, without threat of deterioration to dangerousness and/or dependency.
   - All other persons receiving services, or screened and referred to other community resources.

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the Epidemiologic Catchment Area (ECA) project. The ECA (discussed below) is the only data base of its kind, as it includes diagnostic assessments for about 18,000 individuals in five community resident samples (see Regier et al., 1984; Eaton & Kessler, 1985). Next, a statistical "risk model" was developed that specified the relationship of selected demographic characteristics to the operationally defined Texas priority populations. Finally, the statistical model was applied to the census profile of each county in Texas in order to generate local prevalence estimates.

The project was conceived, then, at the interface between two different spheres of activity—the world of health services planning and policy and the world of epidemiologic research. Clearly, the Texas definitions were not developed as operational measures for needs assessment research, but rather as general policy guidelines for establishing rational priorities in the public funding of services for the mentally ill. The policy question "What kinds of problems are most important to solve with the limited resources available?" may be adequately addressed in general terms. The research question "How large a population of severely and chronically mentally ill persons is not being served?" requires a sharper definition of the specific behaviors, symptoms, and so forth that actually are to be observed, measured, and counted as cases.

As researchers, we were faced with the task of translating the general terms of policy-oriented criteria into certain observable features of individual lives. Moreover, we could not go out and make new observations guided explicitly by these criteria but were limited to available measures in an existing data base, i.e., the ECA surveys. The Texas priority population criteria thus had to be recast in terms of variables existing in the ECA data base. Analysis of the distribution of these ECA variables, and of the relationships among them, was intended to improve our understanding of the Texas criteria and to provide initial estimates of the numbers of people to be found at each level of need for services.

The process of developing operational measures can point out weaknesses and unwarranted assumptions in the original concepts, and thus help to evaluate and sharpen the criteria for determining service priorities. A good example is to be seen in the definitions for Groups I and II (Table 1), where a distinction was made between "chronically dysfunctional" and "historically dysfunctional" disorder. The former term designated psychiatric disorder lasting two years or more, since Group I was meant to include the most severely mentally ill with long-term disorders rendering them dependent and/or dangerous to themselves or others. Group II, the "historically dysfunctional," was meant to include persons whose disorders have not been so protracted, but who are nevertheless quite severely ill, i.e., are presently "dangerous and/or dependent" just as in Group I.

Thus, to exclude the less severely disordered who otherwise might qualify, the Group II definition was made more stringent by adding the criterion of "at least one previous psychiatric hospitalization [or] involuntary commitment to psychiatric services."

The addition of previous hospitalization as a second-priority criterion may appear quite reasonable on a conceptual level. Although hospitalization is not included explicitly in the first-priority definition, it might seem to be implied by the severity of the other criteria. However, when one attempts to operationalize such definitions in a real community data base, two problems arise. First, concerning Group I, it turns out that the majority of community respondents with chronic major disorders who are also dangerous and/or dependent have *never been hospitalized* for a mental health problem. Clearly, this flies in the face of a key assumption often made by state mental health administrators, which is that the population of severely mentally ill individuals in the community consists of people who have at some time occupied psychiatric inpatient beds. Secondly, where Group II is concerned, it turns out that of all community respondents who *do* report a previous psychiatric hospitalization, virtually none has a disorder with recent onset; i.e., symptoms typically develop for many years before a person spends his or her first night in a psychiatric hospital. In sum, as actually measured, neither definition could work the way planners might have intended; Group I included a much larger population than they had in mind, while Group II was virtually nonexistent.

The foregoing discussion should serve as an introduction to the field of mental health needs assessment, both as a research activity and as a policy development tool. The Texas definitions of priority populations provide a concrete starting point for the present application of needs assessment. Before proceeding to the details of our analysis, however, a summary of the nature and design of the ECA data base will provide the remaining necessary background.

### *The ECA Data Set*

*Design.* The ECA project is based on a panel design with coordinated surveys of adult institutional and household resident populations at five sites: New Haven (Yale University), Baltimore (Johns Hopkins University), St. Louis (Washington University), Durham (Duke Unversity), and Los Angeles (UCLA). At each site, 3,000 to 5,000 household residents and 400 to 500 residents of institutions (mental hospitals, nursing homes, prisons) were interviewed. Further details of the sampling design have been reported by Eaton et al. (1984) and Holzer, Spitznagel, Jordan, Timbers, Kessler, & Anthony (1985).

The five-site data can be merged to form one large "sample" of approximately 18,000 cases. This has been accomplished by weighting each sample to the local population based on probabilities of selection followed by post-stratification to census marginals for demographic composition. To keep the weighted sample the same size as the original sample, population weights were downweighted to the sample size for each site before combining the samples. We have used the merged data for the analyses presented herein. Due to the differences in sampling design among the sites, these data provide a sampling variance which may be somewhat larger than that for a simple random sample. Average design effects of 2.0 are typical.

There are some inherent limitations in constructing measures of mental health need from the multisite data base. Sites differ somewhat in the variables they include and in probes for symptom recency and onset. Usually a single probe following a whole diagnostic section in the interview must be used to define the recency or age of onset for a specific symptom of interest.

*Instrumentation.* All of the five ECA sites employed a nearly uniform interview protocol to gather information about psychiatric disorder, utilization of health and mental health services, and sociodemographic characteristics. The core of the interview used at all five sites is the Diagnostic Interview Schedule (DIS) (Robins, Helzer, Croughan, & Ratcliff, 1981). In addition, each site designed unique sections dealing with possible risk factors for disorder and disability.

The DIS is a fully structured instrument designed for lay interviewers to elicit the elements of a diagnosis, including symptoms and their severity, frequency, and distribution over time. DSM-III diagnoses can be generated by computer for various current time intervals or over the respondent's lifetime. The version of the DIS used in the present research covers the following mental disorders: alcohol abuse/dependence, anorexia, antisocial personality, bipolar disorder, drug abuse/dependence, dysthymia, major depression, obsessive-compulsive disorder, panic, phobias, schizophrenia/schizophreniform disorder, and somatization.

### *Operational Definitions of Texas Priority Populations in ECA Data*

Variables can be found in the ECA core data base which approximate most, if not all, of the dimensions in the Texas priority population definitions. The major DSM-III diagnoses themselves include some information about severity of functional impairment. Recency can be established for disorders and some individual symptoms. Chronicity of disorder can be estimated from symptoms that were probed for age of onset. Regarding dangerousness, several of the diagnostic sections include assessments of

violent behavior or suicidality. When a major psychiatric disorder is presumed to be present, dependency can be inferred from items concerning employment status, receipt of unemployment compensation or other fiscal entitlements such as disability, Social Security, and welfare. History of psychiatric hospitalization, a Group II criterion, was assessed in the ECA interview as well.

*Presence of Psychiatric Disorder: Major versus Minor.* In order to operationalize the Texas definitions of priority populations, it was necessary to create a summary measure of the prevalence of psychiatric disorders. The question arose then, which disorders should be included in the summary measure? Our strategy was to construct two kinds of summary measures, one for "major" and one for "minor" disorders, and to exclude the personality disorders on Axis II of DSM-III. Clearly, disorders differ widely in their typical severity; some, by their nature, imply a much more urgent need for treatment than others. These differences between disorders correspond generally to expected levels of functional impairment, dangerousness to self or others, and various social consequences such as isolation, stigma, or legal sanction. Schizophrenia is classified as "major," for example, because it typically is associated with serious impairment of social fuctioning and independent living and also tends to imply a somewhat inevitable and degenerating course. It might be noted that DSM-III avoids prognostications about the course of an illness as a part of its classification; however, typical outcomes do vary, unarguably, from one disorder to another. For purposes of this study, persons who have a major disorder are assumed to exhibit at least the threat of deterioration to dangerousness and/or dependency.

In this analysis, we have included as "major" the schizophrenias, major affective disorders, alcoholism, and drug abuse or dependence (other than cannabis). "Minor" became a residual category including phobias, panic, somatization, dysthymia, obsessive-compulsive disorder, cannabis abuse, and anorexia. These disorders, and their classification, are listed in Table 2.

*Recency and Chronicity.* The timing of symptoms is key information for the diagnosis and treatment of most illnesses. Likewise, for mental health needs assessment and planning, it is important to know *when* a disorder developed, *how long* it lasted, and *how recently* it has been present. Just knowing which symptoms have occurred does not establish need for intervention; they must be "currently" present, or must have occurred "recently." To make certain diagnoses, symptoms must also have persisted for a specified period of time. Duration is especially important to establish because the most chronic conditions, e.g., those that begin in adolescence and persist into adulthood, tend to indicate a higher level of "need for

Table 2

Major/Minor Classification of Disorders Assessed by DIS

| Major | Minor |
|---|---|
| Alcohol abuse or dependence | Anorexia |
| Bipolar disorder | Cannabis abuse or dependence |
| Depression | Dysthymia |
| Depression with grief | Obsessive-compulsive disorder |
| Hard drug abuse or dependence* | Panic |
| Schizophrenia | Phobia |
| Schizophreniform disorder | Somatization |

*Any opioids, barbiturates, amphetamines, cocaine, hallucinogens, *excluding* cannabis.

service," may also be the most resistant to treatment, and may consume an inordinate amount of resources.

What qualifies as a "current" disorder? In this project, "current" was defined as meeting diagnostic criteria for a given disorder and having at least one symptom in the 12 months preceding interview. What qualifies as "chronic" disorder in addition? The Texas guidelines specify "two years duration" as the definition of chronic. In the ECA data, the respondent's age when the first symptom of a disorder occurred was subtracted from the respondent's current age. If the difference was two years or greater, the disorder was presumed to be chronic. Table 3 presents the ECA one-year prevalence of various disorders, chronic and not, based on these criteria. It is clear from this table that most adults who meet diagnostic criteria for a DSM-III disorder have had symptoms for longer than two years; i.e., most psychiatric disorders are "chronic" by nature, according to this definition.

*Danger to Self or Others.* Perhaps the most important societal priority mandating intervention in serious psychiatric disorders is the presumption of danger to self or others. There is little disagreement about this in principle, though the definition, assessment, and prediction of "dangerousness" in relation to mental illness is highly controversial. The State of Texas defines it as follows:

> Present dangerousness involves a condition of substantial likelihood for inflicting injury on self or others, including such recent acts as: combative/aggressive behaviors or convincing verbalizations or menacing overtures toward others; *or* convincing self-injurious verbalizations, self-injury, or actions conveying self-injurous intent. (Texas Department MHMR, 1989)

Table 3

Prevalence of Current and Chronic DIS/DSM-III Disorders

| Selected disorders | Current disorder | |
|---|---|---|
| | Chronic[a] | Recent[b] |
| Schizophrenia | 0.9 | 0.0 |
| Schizophreniform disorder | 0.1 | 0.0 |
| Major depressive episode | 2.7 | 0.5 |
| Depression with grief | 2.8 | 0.7 |
| Manic episode/bipolar disorder | 0.5 | 0.1 |
| Alcohol abuse/dependence | 5.2 | 0.7 |
| Hard drug abuse/dependence | 0.7 | 0.1 |
| Any DIS disorder | 21.1 | 1.5 |

[a] Symptoms for at least 2 years.

[b] One-year prevalence.

In our project, however, any debate about measuring dangerousness was constrained by what the DIS had to offer. The DIS does contain a number of items that seem to indicate actual or potential danger. Danger to self was presumed in suicidal thoughts or attempts, as reported in the DIS section for assessment of depression. For danger to others we used items from the sections on alcohol abuse and antisocial personality having to do with violence and abuse of others: history of fighting, hitting a spouse or child, neglecting a child, getting in drunken brawls, or brandishing weapons.

Table 4 presents these DIS symptoms of dangerousness. Respondents were coded positive if they reported the symptom and during the last 12 months had at least one symptom in the group from which the item was taken.

Table 5 presents the count of symptoms related to violence occurring in the last year. This table shows that symptoms of violence were reported by over 5 percent of the population, with 1.9 percent reporting incidents from two or more categories of violence. The large number of missing cases is due to the fact that the DIS contains a skip-out in the antisocial personality section when respondents report no antisocial symptoms during childhood or adolescence.

**Table 4**

**DIS Symptoms Indicating Dangerousness**

**Danger to others**
- ☐ Hit or threw things at spouse
- ☐ Hit child hard enough to cause bruises
- ☐ Engaged in fights that came to swapping blows
- ☐ Used a weapon in a fight
- ☐ Got into physical drunk fights

**Danger to self**
- ☐ Had suicidal thoughts
- ☐ Attempted suicide

**Table 5**

**Danger to Others: Count of Violence Symptoms Present in Last Year**

| Violence | Weighted frequency | Percent |
|---|---|---|
| 0 | 14,393 | 94.4 |
| 1 | 566 | 3.7 |
| 2 | 193 | 1.3 |
| 3 | 84 | 0.5 |
| 4 | 14 | 0.1 |
| 5 | 4 | 0.0 |

Missing data = 3,319

**Table 6**

**Danger to Self: Suicidality Present in Last Year**

| Suicide | Weighted frequency | Percent |
|---|---|---|
| None | 17,816 | 97.2 |
| Thoughts | 405 | 2.2 |
| Attempt | 105 | 0.6 |

Missing data = 247

**Table 7**

**ECA Items Indicating Dependency Due to Loss of Function**

Months since worked for pay
Receiving disability payments from SSI, VA, state, or other source
Receiving welfare payments
Receiving unemployment

Table 6 presents the occurrence of suicidal thoughts or attempts within the last year. Although less than 1 percent of the population had attempted suicide, there was a larger percentage (2.2 percent) with suicidal ideation.

*Dependency Due to Impairment of Normal Functioning.* The notion of dependency due to loss of normal functioning also is an important criterion of need for services. The Texas definition is as follows: "A condition of inability because of mental disorder to meet basic life support needs, e.g. food, shelter, medical care, without extensive support from others outside the natural support system." (TDMHMR, 1989) The priority population guidelines specify a number of indicators of dependency for adults: unemployment due to mental disorder, strong reliance on financial entitlements, or marked social dysfunction such as failure to meet household health standards, disorderly conduct, or frequent public intoxication. Table 7 presents the ECA variables used to indicate dependency.

Table 8 presents the distribution of work status. Over half of the respondents were working at the time of interview, while 35 percent had not worked during the last year. This group includes persons who are unemployed or disabled, as well as housewives and retirees. It is difficult to determine from any survey the reasons for which people are not working; the ECA is no exception. Older persons sometimes retire due to poor physical or mental health. Some housewives may be retired or disabled. In any case, there are a great many people who report that they are not working, for whatever reason. Thus, it is important to note that employ-

Table 8

Percent Working Full-Time for Pay

| Work status | Weighted frequency | Percent |
|---|---|---|
| Working now | 9,843 | 55.5 |
| Worked in last 12 months | 1,684 | 9.5 |
| Did not work in last 12 months | 6,207 | 35.0 |
| Missing data = 838 | | |

Table 9

Weighted Frequency of Dependency on Financial Entitlements

| Type of benefits[a] | Weighted frequency | Percent |
|---|---|---|
| Disability | 1,007 | 5.5 |
| Welfare | 703 | 3.9 |
| Unemployment | 382 | 2.1 |
| Other Social Security | 2,668 | 14.6 |
| None | 13,492 | 73.9 |

[a] People with multiple benefits are assigned to the highest entry in the list, and therefore may in addition receive benefits listed lower.

ment status is only presumed to indicate "dependency" (in the sense of mental health need) *in the presence of major psychiatric disorder*. That is to say, the meaning of not working changes when we know that a person has schizophrenia, major depression, or alcohol dependence. At least for needs assessment purposes we must assume that work status and psychiatric condition are related—though the causal connection was not assessed directly in the DIS.

Table 9 presents the ECA distribution of dependency on financial entitlements. Some of this disability is federally based SSI while other support comes from state sources. The source is important, because the criteria for eligibility vary somewhat from state to state. Criteria in Texas may be somewhat more restrictive than the criteria applicable to these ECA respondents.

We classified respondents as not working only if they have not worked in the last 12 months or longer. Respondents were classified as dependent on financial entitlements only if they were receiving disability, welfare, or unemployments benefits. Receiving other Social Security payments was not considered for positive classification on this criterion.

Based on the foregoing operational definitions of major disorder, chronicity, recency, dangerousness, and dependence, a 10-level variable was constructed in the ECA data base. Table 10 lists these 10 levels and shows their relationship to the original Texas definitions of the priority populations.

The priority populations variable (designated "PROP") was coded cumulatively, so that prevalence rates for the lower priority levels include all higher priority levels as well. Thus, the rate for Group V (code 6) is the sum of all the priority populations; the rate for Group VI (code 10) includes all persons in need of services, in all priority and nonpriority groups.

Two alternative versions of this varible were used in the final estimates, and the results of both are presented. One version (designated "PROP-A," i.e., mental health only) included only major affective disorders and schizophrenias in the definition of "major disorder" and excluded substance abusers with no other mental disorder. The other version (designated "PROP-D," i.e., mental health and/or substance abuse) included all substance abusers in the definition of "major disorder" with the exception of those who only abused cannabis.

The choice of which version of the estimates to use in planning mental health services is not a trivial one, since the inclusion of substance abusers increases the estimated size of the priority populations overall by at least 50 percent and more than doubles the size of the Group I estimate. Further, the character of the priority populations changes a great deal depending on whether substance abuse by itself is treated as a major disorder. When it is

included, there are many more young males in the high priority groups. In addition, the criteria for these young males' classification in the high priority group more often involve violence toward others, and less often suicidality or dependence.

Table 10

Texas Definitions of Priority Populations
for Mental Health Services Planning and Delivery

| TDMH def. | Oper. code | Definition |
|---|---|---|
| | | *Priority Populations* |
| I.A. | ( 1 ) | Current and chronic major disorder, with dangerousness/dependence, and a prior hospitalization for mental health |
| I.B. | ( 2 ) | Current and chronic major disorder, with dangerousness/dependence |
| II.A. | ( 3 ) | Current major disorder, with dangerousness/dependence, and a prior hospitalization for mental health |
| II.B. | ( 4 ) | Current major disorder, with dangerousness/dependence |
| III. | — | (Not operationalized since the ECA is a community sample) |
| IV. | ( 5 ) | Current and chronic major disorder |
| V. | ( 6 ) | Current major disorder |
| | | *Nonpriority Populations* |
| VI.A | ( 7 ) | Current and chronic minor disorder, with dangerousness/dependence |
| VI.B. | ( 8 ) | Current minor disorder, with dangerousness/dependence |
| VI.C. | ( 9 ) | Current and chronic minor disorder |
| VI.D. | ( 10 ) | Current minor disorder |
| | ( 0 ) | No disorder |

Table 11 illustrates this by showing the ECA rates of violence, suicidality, and dependence among those with chronic major disorders. In general, substance abusers were the most violent (37.9 percent), depressives were the most suicidal (41.7 percent), and schizophrenics were the most dependent (44.7 percent not working, 27.8 percent receiving fiscal entitlements).

Any subsequent estimate of *unmet need* also will be much higher when substance abuse is included, because substance abusers are less likely to seek or receive treatment of any kind. Table 12 presents rates of utilization of mental health services by those in Priority Group I, using the alternative definitions of "major disorder." These data show that the inclusion of substance abusers doubles the size of Group I, but decreases their apparent rate of service utilization by about 25 percent. (See Shapiro et al., 1984, for a general presentation of utilization of services in the ECA.)

Table 11

Percentage of ECA Respondents with Chronic Major DSM-III Disorders Who Are Dangerous and/or Dependent

| | Schizophrenia | Depression | Substance abuse | No disorder |
|---|---|---|---|---|
| Violent | 19.7% | 18.2% | 37.9% | 0.2% |
| Suicidal | 30.7 | 41.7 | 8.3 | 0.4 |
| Not working | 44.7 | 38.0 | 20.6 | 35.8 |
| Fiscal aid | 27.8 | 22.0 | 14.5 | 8.6 |
| Any of the above | 67.6 | 70.6 | 58.7 | 38.5 |

Table 12

Percentage in Priority Group I and Their Use of Mental Health Services

| Included as major disorder | Percentage in Group I | Ever in MH hosp | Any MH service in 6 months |
|---|---|---|---|
| MH[a] only | 2.6% | 24.65% | 37.75% |
| MH and substance abuse | 5.3 | 18.95 | 28.63 |

[a] Major affective disorders and schizophreniform spectrum.

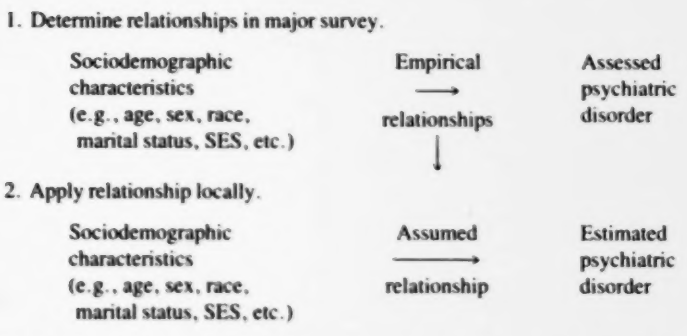
## Extrapolation of ECA Estimates to Texas Counties

### *Indirect Approaches to Estimation*

The basic idea underlying indirect needs assessment is that demographic characteristics have a consistent general relationship to psychiatric disorder in most areas. That is to say, persons with particular demographic characteristics are more likely than others to need mental health services, whether they live in Connecticut, Texas, or elsewhere. Thus, through use of indirect standardization one should be able to estimate needs in Texas from the ECA data. The general methodology termed "horizontal synthetic estimation" has been described elsewhere (Holzer, Jackson, & Tweed, 1981; Holzer, Goldsmith, Jackson, & Swanson, 1988).

Demography-specific prevalence rates can be calculated directly for the five sites surveyed in the ECA project, but there are no such data for other areas where needs assessment may be desired. Using the logic of indirect estimation, however, the ECA rates can be applied to any local area described in the U.S. Census. For example, if the ECA shows that 20 percent of young unmarried males need mental health services, and the Census shows that there are 5,000 young unmarried males in Galveston County, then we can estimate that there are 1,000 young unmarried males in Galveston County who need services. This assumes, of course, that the differences between young unmarried males in Galveston and those in the ECA sites (interviewed in 1980) are not systematically related to psychiatric disorder, or to the need for mental health services. By summing the estimates across all demographic subgroups, an overall estimate of the numbers of people in need of mental health services can be calculated. Figure 1 illustrates the concept of indirect estimation in general.

*Figure 1*. Illustration of extrapolation paradigm.


1. Determine relationships in major survey.
Sociodemographic characteristics (e.g., age, sex, race, marital status, SES, etc.)
Empirical relationships
Assessed psychiatric disorder
2. Apply relationship locally.
Sociodemographic characteristics (e.g., age, sex, race, marital status, SES, etc.)
Assumed relationship
Estimated psychiatric disorder

While the basic idea is a simple one, the actual procedures for indirect estimation are somewhat complex. Figure 2 summarizes the various steps in this technique. Our first step was to divide the ECA survey sample into an optimal set of demographic subgroups or cells defined by those variables that are predictors of psychiatric disorder, including "control" variables that define the conditions under which the predictors operate. To determine the best set of variables that are significant in the definition of these cells, a multivariate model was developed. The final model specifies the effects of five categorical variables: age, sex, race/ethnicity, marital status, and education (high school graduation). Again, it is assumed that the test population (ECA sites) and the target population (Texas) are sufficiently similar on characteristics uncontrolled by the model that the transfer of rate structure from one population to the other is reasonable.

*Figure 2.* Overview of indirect model-based estimation.

1. Determine optimal allocation of population into cells based on sociodemographic characteristics related to disorder.

2. Determine cell-specific rates of disorder (need for service) at ECA sites:

| Sociodemographic characteristics (age, sex, race, marital status, H.S. grad.) | Empirical ⟶ relationships | Cell-specific (crude) rates for priority service groups $r(i, j, k, \ldots)$ |
|---|---|---|

3. Interpolate rates for cells with small sample sizes; "smooth" distributions among other cells:

| Crude rates $r(i, j, k, \ldots)$ | Logistic regression ⟶ | Adjusted rates $r^*(i, j, k, \ldots)$ |
|---|---|---|

4. Estimate local population structure (state, county, region, service area) for cells $i, j, k$, etc., from census projections:

| Sociodemographic characteristics (age, sex, race, marital status, H.S. grad.) | Empirical ⟶ relationships | Cell counts $T(i, j, k, \ldots)$ |
|---|---|---|

5. Apply adjusted ECA rates (for priority service groups) to estimated cell populations in Texas:

| For all $i, j, k, \ldots$ | Estimated cases |
|---|---|
| $r^*(i, j, k, \ldots) \times T(i, j, k, \ldots)$ | $\rightarrow e(i, j, k, \ldots)$ in target cell |

6. Combine cell counts for total estimates of mental health need:

For all $i, j, k, \ldots$

Sum: $e(i, j, k, \ldots)$ ⟶ Total need (cases)

7. Estimate local rates for priority population service groups:

For all $i, j, k, \ldots$

Sum: $e(i, j, k, \ldots)$ ⟶ Total cases (numerator) Overall local

——— [divided by] ——— = prevalence rate

Sum: $T(i, j, k, \ldots)$ ⟶ Population (denominator)

Table 13 shows the levels of these five variables, which defined a total of 144 cells.

It was essential for the ECA cell classification to be identical to the cell classification available in the census data for the state of Texas, our "target area" for indirect needs assessment. Also, the cell structure had to account for a substantial portion of the variance in prevalence rates that is due to sociodemographic variables.

Table 13

Definitions of Cells for Age/Sex/Race/Marital Status/High School Education Model

| | | |
|---|---|---|
| Age: | 18–24; 25–44; 45–64; 65 + | 4 |
| Sex: | Male; female | 2 |
| Race: | White + other; black; hispanic | 3 |
| Marital Status: | Married; separated/widowed/divorced; single | 3 |
| Education: | High school graduate; not H.S. grad. | 2 |
| Total cells: | | $4 \times 2 \times 3 \times 3 \times 2 = 144$ |

Table 14 presents tabulations of the PROP-A and PROP-D variables by the separate demographic variables within the ECA sample. These are two-way tabulations. Regression models are presented below. As can be seen, the rates generally decrease among the elderly. Rates are somewhat higher for men when substance abuse is included, but are higher for women when substance abuse is excluded.

Overall ethnic differences are very small for the high priority populations. However, blacks have somewhat higher rates in the nonpriority categories. Hispanics have slightly higher rates within PROP-D, Group V (D6), corresponding to substance abuse. Rates generally are lowest among married persons and highest among those who are divorced, separated, or widowed. People who have graduated from high school tend to have lower rates than those who have not.

Cross-tabulation of all the demographic variables with the PROP variables produced crude rates of disorder for each of 144 cells. Some resulting cells had very small sample sizes, even in a data base as large as the ECA (five sites combined). The crude prevalence rates for small cells are unstable and therefore likely to give misleading estimates when used for extrapolation. This is especially true for psychiatric disorders, which have low prevalence rates.

Table 14

Percentage of ECA Population in Priority Service Groups*

| | PROP-A, excluding substance abuse | | | | PROP-D, including substance abuse | | | |
|---|---|---|---|---|---|---|---|---|
| | I (A2) | II (A4) | V (A6) | VI (A10) | I (D2) | II (D4) | V (D6) | VI (D10) |
| Age | | | | | | | | |
| 18–24 | 2.9 | 3.8 | 5.5 | 17.0 | 7.9 | 9.9 | 14.2 | 26.2 |
| 25–44 | 3.4 | 3.8 | 6.0 | 17.7 | 6.6 | 7.2 | 12.8 | 24.4 |
| 45–64 | 2.1 | 2.4 | 3.3 | 14.2 | 3.8 | 4.2 | 7.1 | 17.5 |
| 65 + | 1.0 | 1.4 | 1.6 | 10.3 | 2.0 | 2.5 | 2.9 | 11.4 |
| Sex | | | | | | | | |
| Male | 1.4 | 1.8 | 3.0 | 10.7 | 6.4 | 7.2 | 12.9 | 20.2 |
| Female | 3.6 | 4.1 | 5.7 | 19.7 | 4.5 | 5.3 | 7.5 | 21.5 |
| Race/ethnicity | | | | | | | | |
| White + other | 2.6 | 3.1 | 4.4 | 14.4 | 5.4 | 6.1 | 9.7 | 19.5 |
| Black | 2.7 | 3.0 | 4.6 | 19.9 | 5.5 | 6.3 | 10.0 | 25.5 |
| Hispanic | 2.3 | 3.0 | 4.7 | 14.3 | 5.2 | 6.3 | 12.3 | 21.1 |
| Marital status | | | | | | | | |
| Married | 2.0 | 2.2 | 3.3 | 13.4 | 3.9 | 4.3 | 7.3 | 17.2 |
| Div./Wid./Sep. | 3.6 | 4.6 | 6.4 | 20.7 | 6.9 | 8.2 | 12.5 | 25.8 |
| Single | 3.1 | 3.8 | 5.8 | 16.1 | 7.5 | 8.9 | 14.2 | 25.4 |
| High school graduate | | | | | | | | |
| Not H.S. grad. | 2.9 | 3.6 | 4.4 | 17.4 | 6.5 | 7.4 | 10.8 | 22.8 |
| H.S. grad. | 2.4 | 2.8 | 4.5 | 14.4 | 4.8 | 5.4 | 9.5 | 19.8 |

* Coding is cumulative: estimates for lower priority groups include those in all higher priority groups. Estimates are based on weighted data.

We used logistic regression to analyze the distribution of rates among the 144 cells defined by the five variables. Logistic regression is designed to handle dichotomous dependent variables, with either categorical or continuous predictors. It yields coefficients that can be interpreted in terms of relative risk or odds ratios. It also gives an overall measure of the fit between crude cell rates and values predicted by a model. We used logistic regression to examine the strength and significance of demographic

predictors and to generate estimates of the "true" prevalence for each of the cells. When higher-order interactions (three-, four-, and five-way) are removed from the model, the estimated rates for each cell are constrained to follow the general patterns of demographic relationship from the entire data set. Large cells have a major influence on those trends while small cells are "smoothed" to fit the trend. This approach also provides reasonable estimates for cells which may be empty in the original data base. Tables 15 and 16 present the levels of significance for the logistic regression models used for the PROP-A (mental health only) and PROP-D (mental health and/or substance abuse) variables. The significance levels presented are based on weighted data, but have not been adjusted for complex sample design, which generally would lower the level of significance. Although a number of different models were considered, the present models include all main effect and two-way interaction terms, but no higher-order interactions. As can be seen, the main effect terms are highly significant in most of the models, while the interaction terms present a mixed picture. Relatively few of the interactions are significant for the A2, A4, A6, D2, and D4 models while about half are significant for A10, D6, and D10 models. More interactions reach significance for the latter models because they have higher overall prevalence on the dependent variable. The significance of interaction terms would decrease with adjustment for design effects.

*Overall Estimates for the State of Texas*

The next step was to take the cell definitions from the ECA and obtain population counts in each of these cells for the state of Texas by county, region, and local service area. The county population counts for the cells defined were available directly in the 1980 U.S. Census and the NIMH Health Demographic Profile System for age by sex by race by marital status, and for age by sex by race by high school graduation (see Goldsmith et al., 1984). Combining these tabulations provided good estimates for the full demographic matrix for 1980. We then obtained, from the Department of Health, the 1988 projected Texas population estimates by age, sex, and race. These were used to adjust the demographic matrix.

Estimates were prepared by multiplying the smoothed risk rates from the regressions by the corresponding cells in the updated demographic matrix for each county. The cells then were summarized for counties and the state as a whole.

Tables 17 and 18 present a summary of prevalence estimates for selected priority service groups for Texas as a whole. Table 17 presents data based on PROP-A, mental health only, which does not include substance abuse as a major disorder. Table 18 is based on PROP-D, which includes people whose only disorder is substance abuse in addition to those with other

Table 15

Logistic Regression Model, PROP A

| Source | PROP-A2 | | | PROP-A4 | | |
|---|---|---|---|---|---|---|
| | *df* | Chi-sq. | Prob. | *df* | Chi-sq. | Prob. |
| Intercept | 1 | 799.87 | 0.0001 | 1 | 845.42 | 0.0001 |
| AGE4B | 3 | 8.29 | 0.0404 | 3 | 10.20 | 0.0169 |
| FEMALE | 1 | 26.80 | 0.0001 | 1 | 24.75 | 0.0001 |
| RWBH | 2 | 5.15 | 0.0763 | 2 | 11.09 | 0.0039 |
| MARMDS | 2 | 3.23 | 0.1986 | 2 | 8.25 | 0.0161 |
| HSGRAD | 1 | 1.18 | 0.2769 | 1 | 7.83 | 0.0051 |
| AGE4B × FEMALE | 3 | 6.09 | 0.1071 | 3 | 6.29 | 0.0985 |
| AGE4B × RWBH | 6 | 15.82 | 0.0147 | 6 | 10.50 | 0.1052 |
| AGE4B × MARMDS | 6 | 4.68 | 0.5855 | 6 | 4.64 | 0.5913 |
| AGE4B × HSGRAD | 3 | 11.27 | 0.0104 | 3 | 7.21 | 0.0654 |
| FEMALE × RWBH | 2 | 8.20 | 0.0165 | 2 | 14.16 | 0.0008 |
| FEMALE × MARMDS | 2 | 3.05 | 0.2172 | 2 | 3.63 | 0.1631 |
| FEMALE × HSGRAD | 1 | 0.07 | 0.7850 | 1 | 0.02 | 0.8770 |
| RWBH × MARMDS | 4 | 1.24 | 0.8723 | 4 | 2.10 | 0.7182 |
| RWBH × HSGRAD | 2 | 0.36 | 0.8347 | 2 | 1.13 | 0.5680 |
| MARMDS × HSGRAD | 2 | 1.06 | 0.5892 | 2 | 0.80 | 0.6711 |
| Likelihood | 101 | 117.19 | 0.1294 | 101 | 111.89 | 0.2157 |

| Source | PROP-A6 | | | PROP-A10 | | |
|---|---|---|---|---|---|---|
| | *df* | Chi-sq. | Prob. | *df* | Chi-sq. | Prob. |
| Intercept | 1 | 940.38 | 0.0001 | 1 | 1096.01 | 0.0001 |
| AGE4B | 3 | 29.76 | 0.0001 | 3 | 15.85 | 0.0012 |
| FEMALE | 1 | 14.00 | 0.0002 | 1 | 75.47 | 0.0001 |
| RWBH | 2 | 7.02 | 0.0300 | 2 | 17.16 | 0.0002 |
| MARMDS | 2 | 12.38 | 0.0020 | 2 | 9.04 | 0.0109 |
| HSGRAD | 1 | 1.15 | 0.2842 | 1 | 12.36 | 0.0004 |
| AGE4B × FEMALE | 3 | 6.35 | 0.0958 | 3 | 15.15 | 0.0017 |
| AGE4B × RWBH | 6 | 8.32 | 0.2153 | 6 | 22.71 | 0.0009 |
| AGE4B × MARMDS | 6 | 6.03 | 0.4203 | 6 | 27.51 | 0.0001 |
| AGE4B × HSGRAD | 3 | 3.90 | 0.2728 | 3 | 2.25 | 0.5213 |
| FEMALE × RWBH | 2 | 7.51 | 0.0234 | 2 | 2.69 | 0.2603 |
| FEMALE × MARMDS | 2 | 6.32 | 0.0424 | 2 | 21.13 | 0.0001 |
| FEMALE × HSGRAD | 1 | 0.53 | 0.4681 | 1 | 0.29 | 0.5932 |
| RWBH × MARMDS | 4 | 7.42 | 0.1152 | 4 | 16.67 | 0.0022 |
| RWBH × HSGRAD | 2 | 1.24 | 0.5380 | 2 | 8.20 | 0.0166 |
| MARMDS × HSGRAD | 2 | 0.21 | 0.8986 | 2 | 1.26 | 0.5324 |
| Likelihood | 101 | 125.27 | 0.0512 | 01 | 157.00 | 0.0003 |

Total frequency ($N$) = 18,305

**Table 16**

**Logistic Regression Model, PROP D**

| Source | PROP-D2 | | | PROP-D4 | | |
|---|---|---|---|---|---|---|
| | *df* | Chi-sq. | Prob | *df* | Chi-sq. | Prob. |
| Intercept | 1 | 1070.73 | 0.0001 | 1 | 1070.99 | 0.0001 |
| AGE4B | 3 | 30.91 | 0.0001 | 3 | 36.52 | 0.0001 |
| FEMALE | 1 | 15.35 | 0.0001 | 1 | 17.29 | 0.0001 |
| RWBH | 2 | 6.41 | 0.0406 | 2 | 8.01 | 0.0182 |
| MARMDS | 2 | 21.55 | 0.0001 | 2 | 27.44 | 0.0001 |
| HSGRAD | 1 | 9.53 | 0.0020 | 1 | 16.71 | 0.0001 |
| AGE4B × FEMALE | 3 | 3.19 | 0.3632 | 3 | 2.64 | 0.4508 |
| AGE4B × RWBH | 6 | 15.25 | 0.0184 | 6 | 14.22 | 0.0273 |
| AGE4B × MARMDS | 6 | 5.11 | 0.5298 | 6 | 6.12 | 0.4099 |
| AGE4B × HSGRAD | 3 | 16.69 | 0.0008 | 3 | 15.08 | 0.0017 |
| FEMALE × RWBH | 2 | 2.62 | 0.2703 | 2 | 3.32 | 0.1898 |
| FEMALE × MARMDS | 2 | 3.59 | 0.1663 | 2 | 5.44 | 0.0659 |
| FEMALE × HSGRAD | 1 | 0.60 | 0.4404 | 1 | 0.43 | 0.5120 |
| RWBH × MARMDS | 4 | 1.36 | 0.8509 | 4 | 1.53 | 0.8206 |
| RWBH × HSGRAD | 2 | 2.54 | 0.2803 | 2 | 1.12 | 0.5703 |
| MARMDS × HSGRAD | 2 | 7.63 | 0.0221 | 2 | 5.95 | 0.0510 |
| Likelihood | 101 | 135.59 | 0.0123 | 101 | 145.92 | 0.0023 |

| Source | PROP-D6 | | | PROP-D10 | | |
|---|---|---|---|---|---|---|
| | *df* | Chi-sq. | Prob. | *df* | Chi-sq. | Prob. |
| Intercept | 1 | 939.53 | 0.0001 | 1 | 776.72 | 0.0001 |
| AGE4B | 3 | 80.49 | 0.0001 | 3 | 59.46 | 0.0001 |
| FEMALE | 1 | 74.72 | 0.0001 | 1 | 0.09 | 0.7616 |
| RWBH | 2 | 7.75 | 0.0207 | 2 | 7.93 | 0.0189 |
| MARMDS | 2 | 32.00 | 0.0001 | 2 | 24.43 | 0.0001 |
| HSGRAD | 1 | 4.93 | 0.0264 | 1 | 17.91 | 0.0001 |
| AGE4B × FEMALE | 3 | 2.22 | 0.5289 | 3 | 2.27 | 0.5179 |
| AGE4B × RWBH | 6 | 20.39 | 0.0024 | 6 | 28.12 | 0.0001 |
| AGE4B × MARMDS | 6 | 16.25 | 0.0125 | 6 | 25.13 | 0.0003 |
| AGE4B × HSGRAD | 3 | 7.57 | 0.0559 | 3 | 2.49 | 0.4778 |
| FEMALE × RWBH | 2 | 8.18 | 0.0167 | 2 | 3.43 | 0.1803 |
| FEMALE × MARMDS | 2 | 2.05 | 0.3587 | 2 | 28.86 | 0.0001 |
| FEMALE × HSGRAD | 1 | 8.46 | 0.0036 | 1 | 3.50 | 0.0613 |
| RWBH × MARMDS | 4 | 4.37 | 0.3588 | 4 | 14.45 | 0.0060 |
| RWBH × HSGRAD | 2 | 9.64 | 0.0081 | 2 | 12.20 | 0.0022 |
| MARMDS × HSGRAD | 2 | 1.78 | 0.4104 | 2 | 1.89 | 0.3883 |
| Likelihood | 101 | 147.00 | 0.0019 | 101 | 183.86 | 0.0001 |

Total frequency ($N$) = 18,305

## Table 17

### Estimates of Need for Texas (TDMHMR Priority Populations for Mental Health Services, 1988, Excluding Persons Whose Only Disorder Is Substance Abuse)

| Priority group | Total | 18–24 | 25–44 | 45–64 | 65 + | Male | Female | Wh + Oth | Black | Hispanic | Mar | S/W/D | Single | HS( − ) | HS( + ) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Group IA | 85373 | 8648 | 54161 | 21246 | 1318 | 35021 | 50352 | 63617 | 5389 | 16367 | 46070 | 22086 | 17217 | 49574 | 35799 |
| Group IB | 216480 | 38316 | 121491 | 40455 | 16218 | 46721 | 169750 | 155408 | 24822 | 36251 | 122227 | 54753 | 39500 | 72559 | 143922 |
| Group II | 55438 | 21198 | 19020 | 8944 | 6276 | 27346 | 28092 | 37064 | 3567 | 14806 | 17646 | 20309 | 17482 | 29249 | 26189 |
| Group III | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) |
| Group IV | 138573 | 28194 | 86895 | 20632 | 2852 | 56904 | 81669 | 97250 | 18588 | 22735 | 76080 | 33694 | 28798 | 25233 | 113340 |
| Group V | 32447 | 9455 | 20452 | 1724 | 815 | 13696 | 18750 | 18839 | 2450 | 11157 | 10818 | 10126 | 11502 | 7558 | 24809 |
| Priority total | 528311 | 105810 | 302018 | 93002 | 27479 | 179688 | 347523 | 372178 | 54816 | 101317 | 272841 | 140970 | 114500 | 184172 | 344139 |
| Nonpriority | 1282913 | 215894 | 719842 | 310407 | 137980 | 413964 | 868949 | 861034 | 186354 | 235525 | 831977 | 273556 | 177380 | 506[illegible] | 776038 |
| Total need | 1811224 | 321595 | 920760 | 403409 | 165460 | 593652 | 1217572 | 1233212 | 241170 | 336842 | 1104818 | 414526 | 291880 | 691[illegible]7 | 1120177 |
| | | | | | | | Percentages | | | | | | | | |
| Group IA | 0.74 | 0.45 | 0.95 | 0.72 | 0.08 | 0.58 | 0.81 | 0.75 | 0.41 | 0.68 | 0.57 | 1.05 | 0.87 | 1.13 | 0.46 |
| Group IB | 1.77 | 1.99 | 2.14 | 1.38 | 0.95 | 0.78 | 2.72 | 1.82 | 1.89 | 1.51 | 1.50 | 2.59 | 1.99 | 1.66 | 1.83 |
| Group II | 0.45 | 1.10 | 0.34 | 0.30 | 0.37 | 0.46 | 0.45 | 0.43 | 0.27 | 0.62 | 0.22 | 0.96 | 0.88 | 0.67 | 0.33 |
| Group III | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) |
| Group IV | 1.13 | 1.47 | 1.53 | 0.70 | 0.17 | 0.95 | 1.31 | 1.14 | 1.42 | 0.95 | 0.93 | 1.60 | 1.45 | 0.58 | 1.44 |
| Group V | 0.27 | 0.49 | 0.36 | 0.06 | 0.05 | 0.23 | 0.30 | 0.22 | 0.19 | 0.46 | 0.13 | 0.48 | 0.58 | 0.17 | 0.32 |
| Priority total | 4.32 | 5.50 | 5.32 | 3.17 | 1.61 | 3.00 | 5.59 | 4.36 | 4.18 | 4.22 | 3.35 | 6.68 | 5.77 | 4.21 | 4.38 |
| Nonpriority | 10.48 | 11.22 | 10.90 | 10.58 | 8.09 | 6.90 | 13.92 | 10.10 | 14.21 | 9.82 | 10.22 | 12.96 | 8.93 | 11.59 | 9.87 |
| Total need | 14.80 | 16.72 | 16.23 | 13.74 | 9.70 | 9.90 | 19.51 | 14.46 | 18.39 | 14.04 | 13.57 | 19.63 | 14.70 | 15.80 | 14.24 |

## Table 18

### Estimates of Need for Texas (TDMHMR Priority Populations for Mental Health Services, 1988, Including Persons Whose Only Disorder Is Substance Abuse)

| Priority group | Total | 18–24 | 25–44 | 45–64 | 65+ | Male | Female | Wh+Oth | Black | Hispanic | Mar | S/W/D | Single | HS(−) | HS(+) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Group IA | 119041 | 15961 | 70036 | 28650 | 4404 | 63575 | 55466 | 87753 | 10867 | 20421 | 61859 | 32349 | 24834 | 70677 | 48365 |
| Group IB | 527994 | 141945 | 278949 | 75444 | 31657 | 311471 | 216523 | 373632 | 54045 | 100317 | 279513 | 117359 | 131122 | 199920 | 328074 |
| Group II | 91059 | 42088 | 29883 | 9982 | 9105 | 49641 | 41418 | 60100 | 8628 | 22331 | 32901 | 25779 | 32379 | 42152 | 48907 |
| Group III | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) |
| Group IV | 433993 | 82028 | 279963 | 67227 | 4775 | 323396 | 110597 | 278259 | 42893 | 112841 | 249371 | 92240 | 92383 | 131440 | 302553 |
| Group V | 69300 | 17092 | 38266 | 12475 | 1466 | 40807 | 28493 | 35974 | 7253 | 26073 | 25703 | 12527 | 31070 | 22335 | 46965 |
| Priority total | 1241387 | 200116 | 697097 | 193767 | 51407 | 788891 | 452497 | 835718 | 123687 | 281982 | 649347 | 280254 | 311787 | 466523 | 774864 |
| Nonpriority | 1240656 | 203368 | 603272 | 297908 | 136108 | 380886 | 859770 | 837299 | 189967 | 213390 | 804677 | 247620 | 188358 | 466652 | 774004 |
| Total need | 2482043 | 502484 | 1300369 | 491675 | 187515 | 1169777 | 1312267 | 1673018 | 313654 | 495371 | 1454024 | 527874 | 500145 | 933175 | 1548858 |
| | | | | | | | Percentages | | | | | | | | |
| Group IA | 0.97 | 0.83 | 1.23 | 0.98 | 0.26 | 1.06 | 0.89 | 1.03 | 0.83 | 0.85 | 0.76 | 1.53 | 1.25 | 1.62 | 0.61 |
| Group IB | 4.31 | 7.38 | 4.92 | 2.57 | 1.86 | 5.19 | 3.47 | 4.38 | 4.12 | 4.18 | 3.43 | 5.56 | 6.60 | 4.57 | 4.17 |
| Group II | 0.74 | 2.19 | 0.53 | 0.34 | 0.53 | 0.83 | 0.66 | 0.70 | 0.66 | 0.93 | 0.40 | 1.22 | 1.63 | 0.96 | 0.62 |
| Group III | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) | (A) |
| Group IV | 3.55 | 4.26 | 4.93 | 2.29 | 0.28 | 5.39 | 1.77 | 3.26 | 3.27 | 4.70 | 3.06 | 4.37 | 4.65 | 3.01 | 3.85 |
| Group V | 0.58 | 0.89 | 0.67 | 0.43 | 0.09 | 0.68 | 0.46 | 0.42 | 0.55 | 1.09 | 0.32 | 0.59 | 1.56 | 0.51 | 0.60 |
| Priority total | 10.14 | 15.55 | 12.29 | 6.60 | 3.01 | 13.15 | 7.25 | 9.80 | 9.43 | 11.75 | 7.98 | 13.27 | 15.70 | 10.67 | 9.85 |
| Nonpriority | 10.14 | 10.57 | 10.63 | 10.15 | 7.98 | 6.35 | 13.78 | 9.82 | 14.48 | 8.89 | 9.88 | 11.73 | 9.48 | 10.67 | 9.84 |
| Total need | 20.28 | 26.12 | 22.92 | 16.75 | 10.99 | 19.50 | 21.03 | 19.62 | 23.91 | 20.65 | 17.86 | 25.00 | 25.18 | 21.34 | 19.69 |

mental disorders. Within both tables, both numerators and percentages are presented. The numerators are the estimated numbers of cases for the state, and the percentages reflect the rate after controlling for population denominator. The columns of the tables, from left to right, provide the estimates for the state overall and separately by age, sex, race, marital status, and high school graduation.

The estimate of the total number of adults in the five priority populations combined is 528,311 cases (4.32 percent of all adults) when substance abuse is ignored and 1,241,387 (10.14 percent of all adults) when substance abuse is included. The overall pattern of demographic characteristics found in the ECA is retained in these Texas estimates. Estimates are higher among younger persons and lower among the elderly. They are higher for females when substance abuse is ignored, and higher for males when substance abuse is included. Priority estimates do not vary greatly by race when substance abuse is ignored, but the inclusion of substance abuse markedly increases the estimates for Hispanics. Estimates are lowest for persons who are married. When substance abuse is ignored, rates are highest for the separated/widowed/divorced, but highest for singles (never married) when substance abuse is included. When substance abuse is included, estimated need is higher for persons who did not finish high school, but otherwise high school graduation appears to make little difference. In sum, when alcohol and drug abuse are viewed as major disorders in the definition of priority levels for mental health services, the population designated as needing services will be disproportionately younger and will more often be male, never married, Hispanic, and without a high school education.

*County Estimates of Need*

The assessment of need by county is of strategic importance. Fiscal resources usually are distributed by county or catchment area, and services actually are delivered in local areas. In the absence of other information, one might assume an even distribution of need across the state of Texas. In fact, a part of the state mental health budget presently is distributed on a per capita basis. However, we already have demonstrated that demographic groups differ in level of need, and we know from census data that counties differ in demographic composition. Thus, needs assessment should consider the geographic pattern of need for services. This can be accomplished in the present case by making separate estimates for each of the counties based on demographics. Our main caveat is that a number of potentially stressful local conditions are not yet included in the demographic model. For example, the model does not adequately deal with the local effects of changes in the Texas oil economy.

Using the models, we have generated detailed estimates of the priority populations for each county, region, and local service area in Texas. These tables have been provided to the Texas Department of Mental Health and Mental Retardation for use in state planning and for distribution to local mental health planners. There are too many pages of tables to be included in this paper; therefore, we have attempted to summarize this information in the following maps.

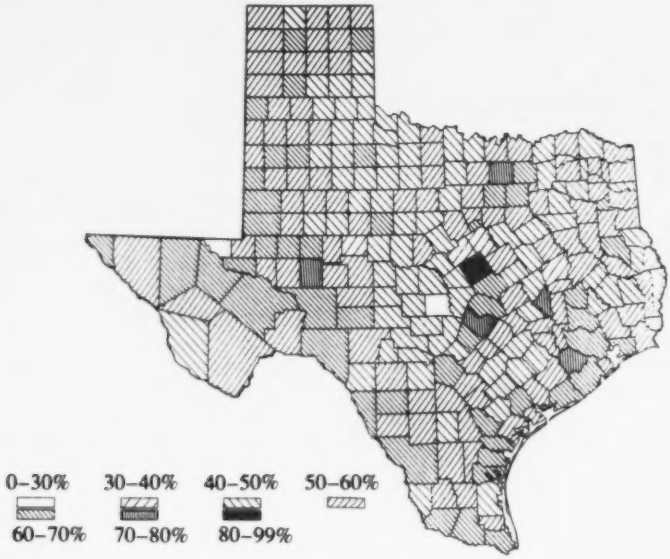
Maps 1–4 illustrate differentials in demographic composition among counties, for selected variables. Map 1 shows the percentage of adults who are aged 18–44 years. There tend to be more young adults (darker color) concentrated in the urban counties and in the border area of South Texas. Counties with military bases and universities are the most prominent. Map 2 shows the percentage of adults who are married. The pattern tends to be the reverse of that seen in Map 1, since younger people are less likely to be married.

Map 3 shows the percentage of adults who are of Hispanic origin. Clearly, the concentration of Hispanics increases with proximity to the Mexican border. Map 4 shows the percentage of adults who are high school graduates. Again, South Texas has the smallest percentage of adults with a high school education. This may reflect immigration from Mexico, where comprehensive public education ends earlier than in the United States. There is also a high dropout rate in the border-region high schools. These four maps serve to illustrate some of the demographic differences among counties. We would expect the geographic distribution of need for mental health services to be influenced by these demographic patterns.

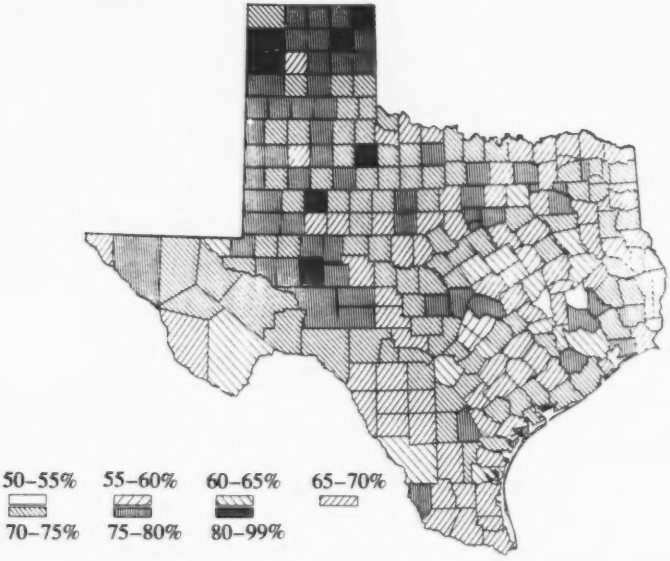
The remaining maps present the county distributions for levels of need. Maps 5–8 present county distributions for PROP-A, which ignores substance abuse in its definition of need. PROP-A2, which represents the chronically mentally ill with dangerousness and/or dependence, shows concentrations in urban counties that typically have more young and unmarried people. This general pattern is preserved for the lower priority levels of PROP-A.

Maps 9–12 present county distributions for PROP-D, which includes substance abuse in the definition of need. PROP-D estimates of need also concentrate in urban counties. The inclusion of substance abuse has the major effect of increasing the estimated prevalence rates, but also differentially increases the estimates for the predominantly Hispanic areas of South Texas.

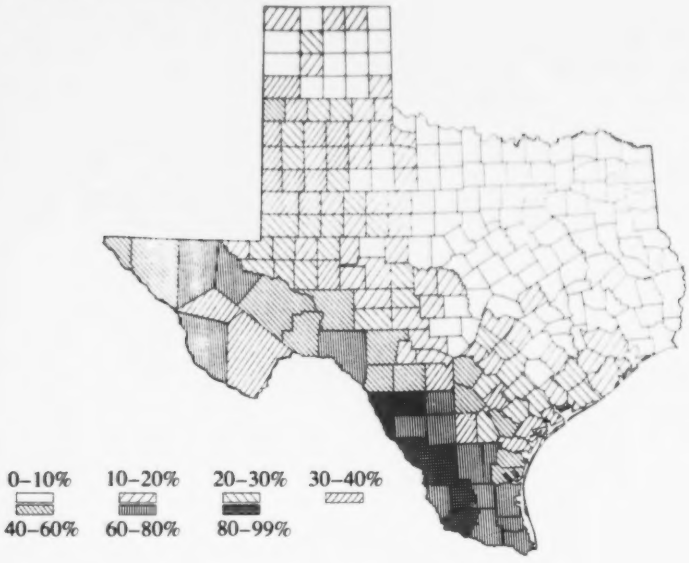
*Map 1*. Percent adults age 18–44 (1988).



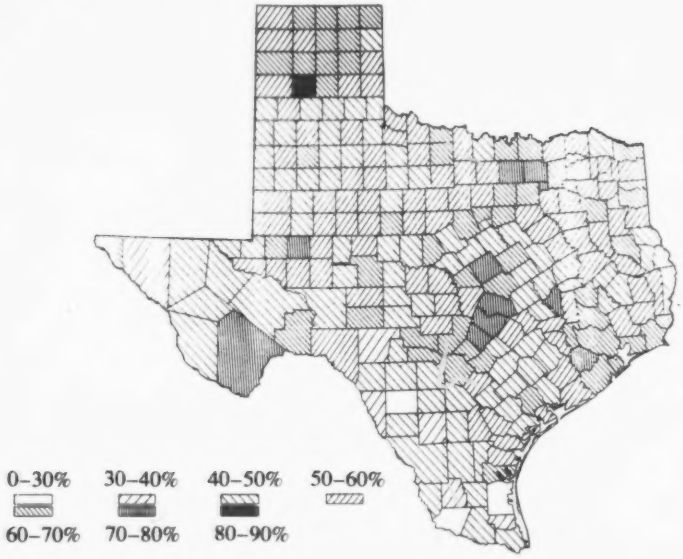

*Map 2*. Percent adults who are married (1988).



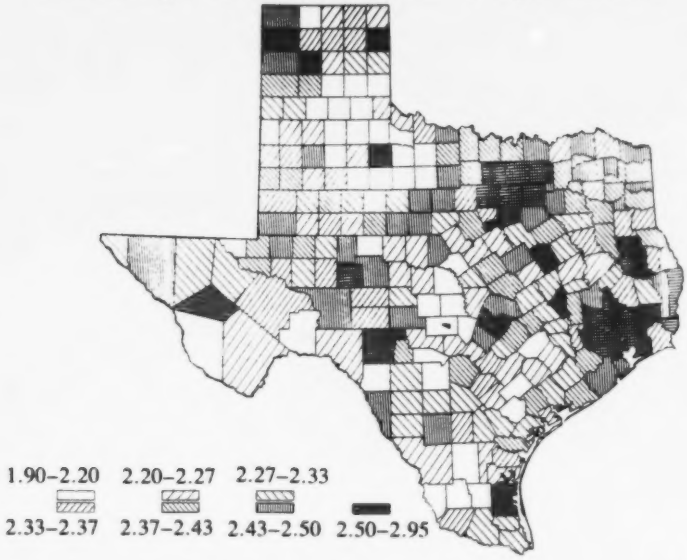
*Map 3*. Percent Hispanic (1988).



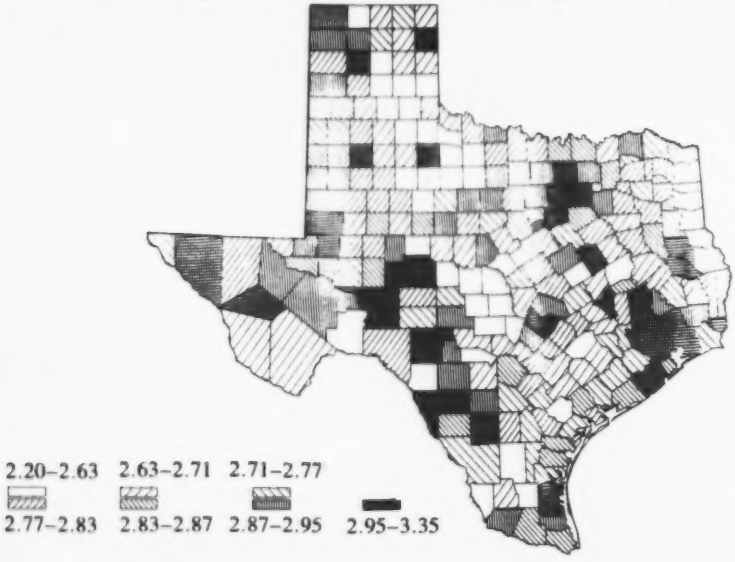

*Map 4*. Percent high school graduates.



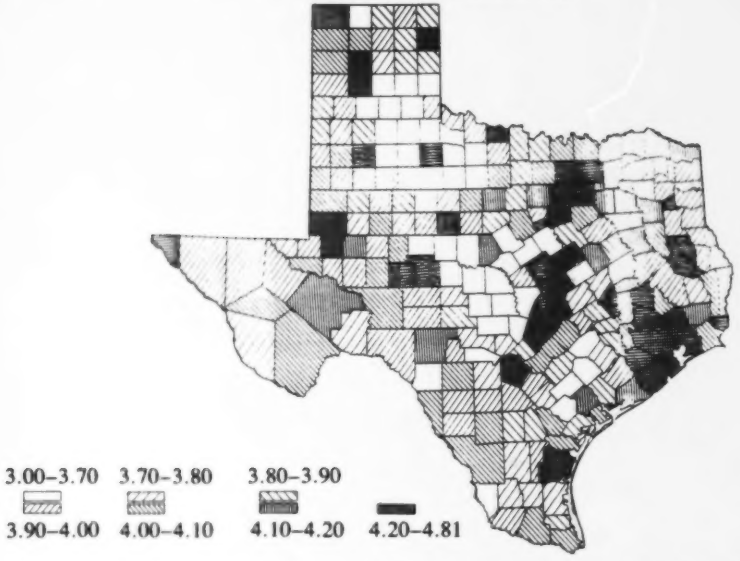
*Map 5*. Prevalence Estimates (1988) for Priority A2 and Higher, Chronic Major Disorder with Dangerousness and/or Dependence (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



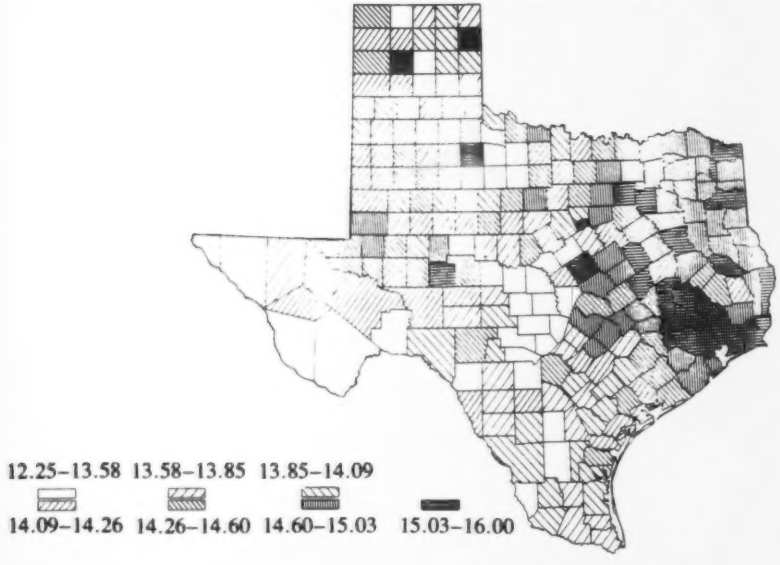

*Map 6*. Prevalence Estimates (1988) for Priority A4 and Higher, Current Major Disorder with Dangerousness and/or Dependence (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



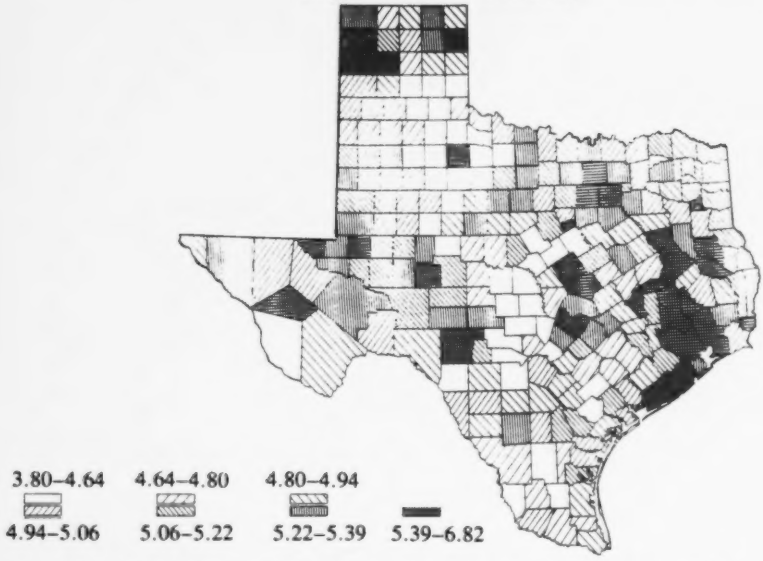
*Map 7.* Prevalence Estimates (1988) for Priority A6 and Higher, Current Major Disorder (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



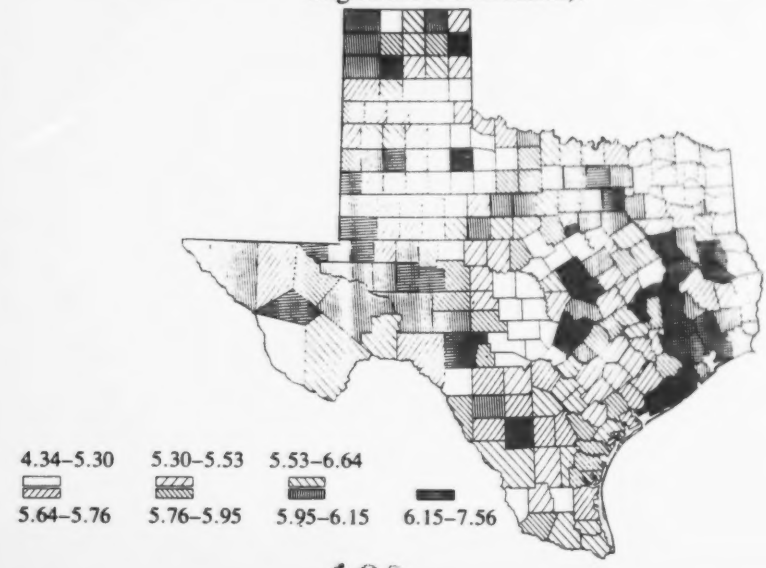

*Map 8.* Prevalence Estimates (1988) for Priority A10 and Higher, Current Major or Minor Disorder (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



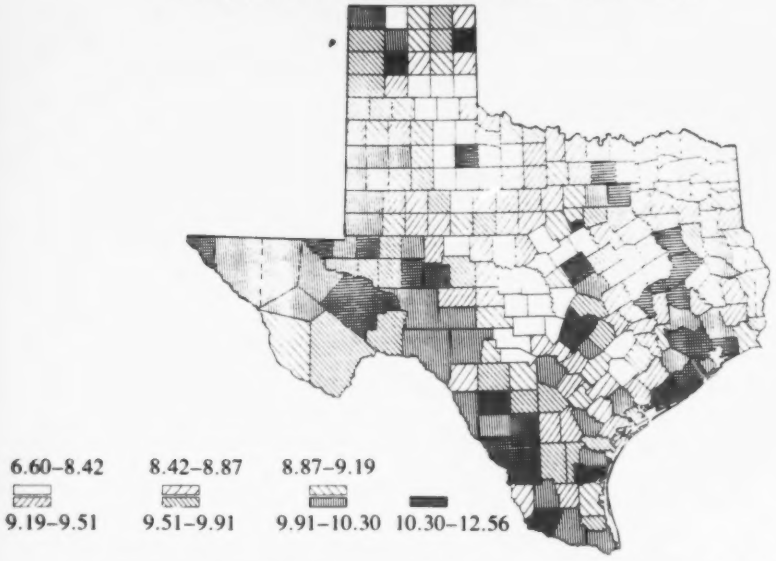
*Map 9*. Prevalence Estimates (1988) for Priority D2 and Higher, Chronic Major Disorder or Substance Abuse with Dangerousness and/or Dependence (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



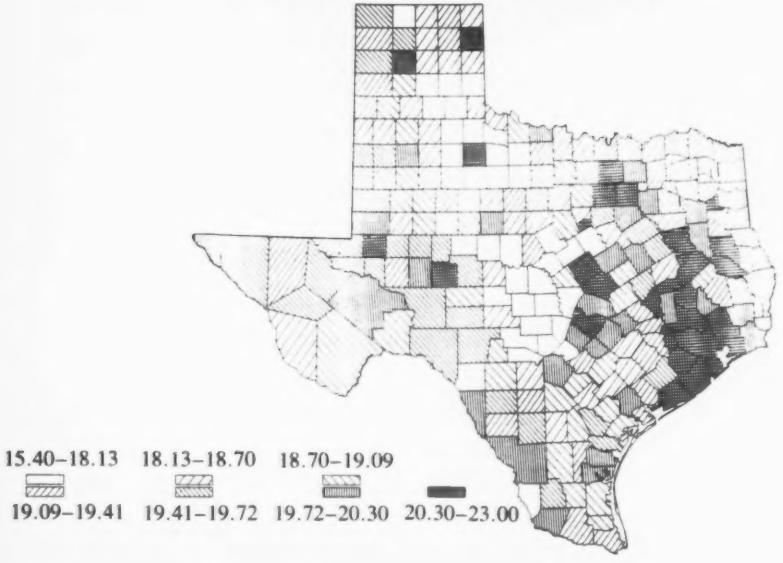

*Map 10*. Prevalence Estimates (1988) for Priority D4 and Higher, Current Major Disorder or Substance Abuse with Dangerousness and/or Dependence (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



*Map 11*. Prevalence Estimates (1988) for Priority D6 and Higher, Current Major Disorders or Substance Abuse (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).




*Map 12*. Prevalence Estimates (1988) for Priority D10 and Higher, Current Disorder or Substance Abuse (ECA Model Based on Age, Sex, Race, Marital Status, High School Graduation).



## Implications of the State and County Estimates

In this paper we began with the mandated Texas definitions of priority populations for mental health services and have operationalized them using data from the NIMH Epidemiologic Catchment Area surveys. The analysis of the empirical interrelationships among the priority criteria has provided a better understanding of their implications, and indeed has led to reconsideration of some parts of the definitions.

The availability of the operational priority definitions also has made it possible to develop a demographic risk factor model, and to use that model to make indirect estimates of need for services in Texas counties. Although this approach has a good theoretical and empirical basis (Bloom, Goldsmith, & Lin, 1988; Goldsmith, Lin, Bell, & Jackson, 1988; Holzer et al., 1988), it is a relatively new methodology that has yet to be evaluated against direct assessments of need. In order to validate this indirect needs assessment approach, it will be necessary to compare estimates made with this methodology to direct estimates from community surveys. Comparison with rates of treated disorder also would be informative but would not constitute a validation. A diagnostic survey of Texas would be extremely useful both for planning and for these validation efforts. In fact, such a survey is in progress for several counties in Texas, as a constituent project of the Center for Cross-Cultural Research that recently has been established in Galveston and Houston.

What we have presented are estimates of need based solely on demographic risk factors, which cannot possibly take into account all of the local influences on need for mental health services including existing treatment programs.

Given this limitation, we must pose the question, How should these estimates actually be used in the planning of services for the state of Texas? As a minimum, we think that these estimates should challenge planners to consider the real differences among local areas in need for mental health services. We have demonstrated that these differences include amount of need, but also the type of need, as illustrated by definitions which include or exclude substance abuse.

Also, these estimates should lead to expanded efforts in needs assessment that would confirm or modify the present picture. In particular, this would include community surveys in Texas using appropriate assessments of disorder and the other priority criteria, such as dangerousness and dependence. The Texas Department of Mental Health and Mental Retardation already is assessing these criteria in their client base, but such efforts should be expanded into the community. Such surveys could focus on areas that we have estimated to be high or low in need using the indirect model-based methods, but ideally would be statewide.

A question arises as to whether the indirect estimates should be used in the allocation of funds. We do not think that the present estimates by themselves should be used to determine the allocation of funds. It would be reasonable, however, to use the estimates, along with supporting local information, to evaluate and modify the current per capita allocations, so that identified priority groups could be served better.

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# Financial Costs of Caring for the Chronically Mentally Ill in Texas*

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Financing care for the chronically mentally ill is one of a number of interrelated issues facing Texans this fall. In a sense, these issues are partially related to the question of how Texas will structure its tax and expenditure programs to benefit most from the federal fiscal system. With regard to mental health, it is important that program designers structure the incentives implicit in any fiscal arrangements to elicit appropriate programs and priorities for the clients served.

In the analysis which follows, we do not directly identify the chronically mentally ill. At the clinical level, there is some debate about which diagnoses comprise chronic mental illness. At the social services level, programs frequently are designed for client populations more broadly or elsewhere defined. Therefore, we have depended on the assessments of administrators and evaluators of specific programs regarding the percentage or number of their clients who are "chronically mentally ill" and the resources consumed by such clients. Alternatively, we have tried to identify expenditures for care of persons with certain diagnoses. Because of these limitations, it is likely that there is some inconsistency in the definitions between programs. It is beyond the scope of this paper to address entirely some of these definitional problems, since the primary data generally are not available to us. Nonetheless, we hope that the results are suggestive and that this paper will help focus interest on this population and on the levels and the mix of services available to them.

We first examine current patterns of state and local expenditures for mental health in Texas, attempting to relate these expenditures to the chronically mentally ill. In the second part of the paper, we discuss some

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possible changes, as well as some of the research priorities we believe exist for the study of financing the care of the chronically mentally ill in Texas.

## Current Patterns of Expenditure

Cost-of-illness studies have become a standard fixture when discussing a disease or groups of diseases. Following the work of Rice and others, these studies document both the direct and indirect costs of illness (Rice, 1969; Cooper & Rice, 1976; Goldman, 1987). The direct costs are the medical care and service delivery costs required by the illness or condition. The indirect costs are the costs of lost productivity or income because those who were sick either could not work due to their illness or died earlier than would have been anticipated if they didn't have the illness.

The direct costs for the chronically mentally ill in Texas are the actual expenditures on their care. Also encompassed in the direct costs are the imputed expenditures by family and friends, who care for these people privately using resources that would be available for other activities if the care were not provided. To estimate this cost, we look at expenditures in the state mental health delivery system and then discuss direct mental health care expenditures outside the formal state delivery system, as well as other expenditures made to support the chronically mentally ill.

The core of the state-supported mental health care system is the Texas Department of Mental Health and Mental Retardation (TDMHMR), the associated community centers, and Texas's Medicaid system, which is administered by the Texas Department of Human Services (TDHS). In addition to these core clinical programs, a number of other programs offer food, income support, training, housing, and social services to the mentally ill. Table 1 estimates the cost of some of these programs and the percentages devoted to the chronically mentally ill.

### *Care in State Hospitals and State Centers*

TDMHMR budgeted $195.6 million for state mental hospital care in FY 1987. This does not include any allocation of TDMHMR overhead to the hospitals. Our estimate that 45 percent of the expenditures were allocated to the chronically mentally ill is based on our estimate that 45 percent of the bed days at state hospitals are attributable to schizophrenia and related disorders and other organic disorders (Table A-2). The trend for utilization at the state hospitals has been on the decline, and that decline is expected to continue. The *R.A.J.* lawsuit has induced the state hospitals to lower their censuses in order to comply with the court's rulings. Under *R.A.J.* the average daily census dropped from 3,900 in June 1983 to 2,500 in March 1988 (Texas Department of Mental Health and Mental Retardation, 1988, p.23). So, though state mental hospital care for the chronically mentally ill

will continue to be important, a decline in its percentage of total expenditures may be anticipated.

The state centers are community centers run by the TDMHMR. Projected average daily census is used to allocate 32.7 percent of the $27.2

Table 1

Estimate of State, Local, and Federal Expenditures of Caring for the Chronically Mentally Ill (CMI) in Texas in 1987

| | Total Mental Health Expenditures | Proportion CMI | Estimated Expenditures for the Chronically Mentally Ill |
|---|---|---|---|
| 1. State hospitals | $195,580,103 | .45 | $88,011,046 |
| 2. State centers | 8,912,914 | .70 | 6,239,040 |
| 3. Community centers | 116,659,516 | .70 | 81,661,661 |
| 4. Texas Dept. of Corrections | 32,192,516 | .35 | 11,267,380 |
| 5. Other criminal justice | NA[a] | NA | NA |
| 6. Medicaid | | | |
| Acute hospital | 9,452,823[b] | | 6,534,728 |
| Physician and other | 4,204,663[b] | | 2,901,217 |
| Outpatient hospital | 292,959[b] | | 202,141 |
| Vendor drug | 5,047,486[b] | | 5,047,486 |
| Nursing homes | 138,979,066 | .40 | 55,591,622 |
| 7. Medicare | NA | NA | NA |
| 8. Local hospital districts | 550,000,000 | .05 | 27,500,000 |
| 9. State medical schools and affiliated institutions | | | 26,000,000 |
| 10. Food stamps | | | 17,956,800 |
| 11. SSI | | | 59,142,780 |
| 12. SSDI | | | 32,206,756 |
| 13. Vocational rehabilitation | 66,321,677[c] | .05 | 3,316,084 |
| 14. VA, inpatient and outpatient | | | 23,000,000 |
| 15. Housing | NA | NA | NA |

*Source:* See text and appendix tables.

[a] NA = Not available.

[b] 1985 figures.

[c] Represents total expenditures, not just mental health.

million budgeted figure to mental health. We then assumed that 70 percent of the mental health funds were spent on the chronically mentally ill. The 70 percent figure assumes the same percentage of state center clients are chronically mentally ill as were found for community mental health agencies in Texas as a whole (Emery & Goplerud, 1988).

*Community Centers*

Community mental health centers (CMHC) in Texas spent $116.7 million in FY 1987 on mental health activities. These funds came from a variety of sources including local tax revenue, patient fees, state grants and contracts, federal funds passed through the state, and other federal funds. (See Tables A-3 and A-4.) We recognize the imbalance between reported community mental health center revenues and expenditures. With the existing data, we have been unable to reconcile the difference. Although it is not possible to be definitive about what percentage of these funds is spent on the chronically or seriously mentally ill (SMI), we have taken the 70 percent figure from the Emery and Goplerud survey. This national survey was conducted in the spring of 1987 under the aegis of the National Council of Community Mental health Centers. It is based on returned surveys from 595 centers, which represented 58 percent of those queried. This survey defined seriously mentally ill persons as having a diagnosis of schizophrenia, organic mental disorder, other psychoses, major affective disorder, personality disorder, and any of the following characteristics:

> a) has had, in the past two years, one or more episodes of psychiatric treatment more intense than voluntary outpatient care (e.g., outpatient commitment, voluntary or involuntary inpatient, partial hospitalization/day treatment, emergency, alternative home care);
> b) has received supportive residential care during the past two years; or
> c) shows significant impairment in level of functioning (e.g., receives SSI or SSDI for mental disability, requires help with basic living skills, poor work history).

From these data, Emery and Goplerud estimated for each state the percentage of the total mental health agency caseloads dedicated to the SMI. The 70.3 percent calculated for Texas community mental health centers was the second highest after Washington state's 74.7 percent (Emery & Goplerud, 1988). In 1987 Texas was spending $19.81 per 1,000 population on community mental health centers, while the national average was $32.46 (Emery & Goplerud, 1988).

*Texas Department of Corrections*

Of the 38,000 inmates at the Texas Department of Corrections, it is estimated that roughly 3,000 are mentally ill, of whom 200–300 can be classified as chronically mentally ill. We have chosen to allocate 35

percent of the 1988 TDC $32.1 million appropriation for psychiatric services for the chronically mentally ill.

*Other Components of the Criminal Justice System*

Public funds certainly are spent on the chronically mentally ill in other portions of the criminal justice system. Police spend many hours answering public disturbance calls, investigating crimes allegedly committed by mentally ill individuals, serving mental illness warrants and transporting persons to public hospitals and mental health facilities (Murphy, 1986). Another expense which we have been unable to calculate is the cost of retaining a mentally ill individual in a county or city jail. Some persons incarcerated for criminal activity are in that situation as the result of a mental illness. Similarly in 1988, the Texas Board of Pardons and Paroles estimated that 13 percent of the 46,000 persons it was supervising were classified as having a severe problem with emotional stability (League of Women Voters of Texas Education Fund, 1988, p. 32). According to the Texas League of Women Voters, approximately 3,000 persons with mental illness in metropolitan areas were directed to the Intensive Supervision Program for high-risk and high-need offenders of the prison system (League of Women Voters of Texas Education Fund, 1988, p. 32).

Several special units have been created within the criminal justice system to address the specific needs of the mentally ill. Mental health units in police and sheriff's departments throughout the state are responsible for answering calls involving persons believed to be mentally ill. Additionally, a special adult probation officer has been designated in some areas to supervise the activites of mentally ill clients. In some respects, these probation officers act as the individuals' case managers—ensuring the clients receive their food stamps, income support, and so forth.

*Texas Medicaid Program*

The Texas Medicaid program pays for medical services provided to eligible persons in institutions, other than institutions for mental diseases. These services include inpatient hospital care, physician and skilled nursing care, and outpatient psychiatric services, which are limited to $312.50 per year. Optional services covered in Texas under Medicaid include vendor drugs, intermediate care facilities (ICF), ICF for the mentally retarded, and community care facilities. Our estimates for Medicaid expenditures in 1987 for the mentally ill come from several sources.

For acute hospital care, we assumed that Medicaid payments under diagnosis related groups 430 (childhood mental disorders), and 432 (other diagnosis of mental disorders) were totally for the chronically mentally ill.

It should be noted that these do not cover physician reimbursement or payments for covered services in state hospitals. Nevertheless, since Medicaid payments to state hospitals are considered an offset to the TDMHMR budget and deposited in the general fund, these funds are counted in Table 1—they just are not identified as Medicaid. The $6,534,728 in Table 1 was the actual Medicaid payment for these diagnoses in 1987 (Texas Hospital Association, 1988). The total mental health expenditure for hospital care under Medicaid of $9,452,823 in Table 1 is data for a broader variety of diagnoses, and by 1987 surely was higher.

Similarly, the figures for outpatient hospital and physician and other are from the 1984 estimates included in the report to the lieutenant governor. We allocated these to the chronically mentally ill in 1987 based on the ratio (.69) that existed between actual 1987 Medicaid hospital reimbursement for the chronically mentally ill and total Medicaid hospital psychiatric expenditures in 1984. For vendor drugs, the 1984 figure was for anti-psychotic drugs. We assume that a reasonable 1987 estimate for the chronically mentally ill in this case is at least equal to the total expenditures in 1984.

For nursing home care, the report to the lieutenant governor found that approximately 28 percent of individuals in the Texas long-term care institutional system have primary or secondary psychiatric diagnoses coded 295.00 to 315.99 (Texas Department of Human Resources and Texas Department of Mental Health and Mental Retardation, 1985) according to the International Classification of Disease (ICD). We estimate total mental health expenditures for nursing homes under Medicaid for 1987 by taking 28 percent of the amount budgeted for Medicaid nursing home care in the Department of Human Services 1987 budget. Then, since many persons with a secondary psychiatric diagnosis are in nursing homes for other reasons, we take 40 percent of this total and attribute it to the chronically mentally ill.

*Local Hospital Districts and State Medical Schools*

In Texas, there is another major source of financing for indigent care. Local hospital districts and city-county governments in the larger cities provide services regardless of ability to pay. In 1986 hospital district local tax levies alone were $485,309,241 (Dunkelberg, 1988, p. 194). In addition, counties without a hospital district have a statutory responsibility to spend up to 10 percent of their general revenue tax levy on indigent care if enough qualifying care is given to indigent county residents. We use an estimated figure for 1987 of $550 million for all local tax levies spent on hospital district care, plus indigent care responsibilities. We estimate that 5 percent of hospital district expenditures went to caring for the chronically

mentally ill. This percentage is not higher because in several of the hospital districts the mental health workers in the emergency rooms are paid by the CMHCs.

In order to verify this estimate indirectly, we examined the psychiatric inpatient days at selected Texas public hospitals as shown in Table A-9. These hospitals accounted for 58,428 acute care psychiatric inpatient days in 1986. In addition, hospitals such as Brackenridge in Austin which do not have licensed psychiatric beds were not included. On the other hand, all of these were not days for the chronically mentally ill, and some of the stays surely were covered by insurance or other government programs. Finally, emergency room expenditures made by these hospitals for the care of the chronically mentally ill are not included. Although it is not possible to know exactly how much of this care went to the chronically mentally ill, the financially dependent mentally ill usually are taken to the emergency rooms of large public hospitals when they need acute care. In 1986 the expenses for an average day in a Texas public hospital represented $633 (Texas Department of Health, 1988). Given this and given the exclusions and qualifications enumerated above, our estimate of $27.5 million in 1987 seems quite reasonable.

State-supported medical schools also provide a substantial amount of care to indigents in affiliated hospitals and clinics. The University of Texas estimated that in 1986 it provided $172.7 million in free care, which could be attributed directly to general revenue appropriations (University of Texas System, 1987). We estimate that in 1987 The University of Texas spent approximately $16 million on the chronically mentally ill at its four medical schools and affiliated institutions. Eight million dollars was spent for the care of the chronically mentally ill in the psychiatric unit at John Sealy Hospital in Galveston. UT staffs and helps operate the Harris County Psychiatric Center, which spent $18.2 million for care of the mentally ill in 1988. The UT Mental Sciences Institute spent $3.6 million in 1987 on mental health research. In addition faculty and residents at UT-affiliated hospitals such as Herman, John Sealy, Medical Center in San Antonio, and Parkland provided free care. One additional expense partially covered by the state-supported medical schools is the cost of residency training for medical students. Hospitals generally pick up the bulk of the residency expense, but the schools do contribute a small portion of the funds. In addition, the four other medical schools—Baylor, Texas A&M, Texas Tech, and the Texas College of Osteopathic Medicine—provide uncompensated care at their affiliated hospitals and clinics. In total, we estimate that the eight medical schools in Texas provided care to the chronically mentally ill at a cost of $26 million in state-appropriated funds.

*Medicare*

Medicare is the primary health insurance program for the elderly. Unfortunately, at this time we do not have expenditure data for Medicare by diagnosis. In response to a request, the Texas Medical Foundation (the Texas Peer Review Organization) found 1,972 Medicare admissions between March 1987 and February 1988 which were attributable to primary diagnoses with ICD codes ranging from 294.0 to 299.9. These admissions included other organic psychotic conditions, schizophrenic psychoses, affective psychoses, paranoid states, other nonorganic psychoses, and psychoses of origin specific to childhood. Since there are roughly 1.6 million Medicare beneficiaries in the state, this would seem to be a relatively low rate of utilization.

Since many persons who are seriously mentally ill qualify for SSDI and Medicare, it might be anticipated that many nonelderly seriously mentally ill individuals would have such coverage. In other research we found that of 36,100 discharges in 1984 in California of persons with a primary or secondary diagnosis of schizophrenia 7,189 were covered by Medicare. Of these, more than 70 percent were less than 65 years of age. Further, we found that Medicare accounted for 106,817 days of care in that state for such patients in 1984 (Crumpton, Stolp, & Warner, 1988). If Texas's utilization actually is similar to California's, then Medicare expenditures for persons with schizophrenia alone would amount to more than $30 million annually.

*Income Support, Housing, and Social Services*

It is valuable to look at the other sources of expenditure for the chronically mentally ill detailed in Table 1, since it is, in part, through expansion of many of these programs that the direct costs in the health and mental health care sectors can be reduced.

*Housing*. Housing remains one of the greatest unmet needs of the chronically mentally ill. A coordinated effort has not been made to provide housing to these individuals or to acquire all of the resources available for housing at the federal, state, and local levels. We have been unable to develop estimates of housing expenditures by public entities on behalf of the chronically mentally ill. A portion of the funds made available under the Stewart B. McKinney Homeless Assistance Act is reserved for developing housing for the chronically mentally ill. These funds are passed through TDMHMR to the community centers and are reflected in the community center expenditure data in Table 1. The McKinney funds have been targeted to community mental health centers in seven of the state's largest cities. There also are a number of other programs, including HUD Section 8 rental assistance, HUD 202 funds for new facilities for the

homeless, community development block grants, and public housing and bonding authorities at the local level. Obviously, some chronically mentally ill persons currently live in such housing. However, most community organizations are unaware of, or intimidated by, the filing process for receiving the funds. Development of a more aggressive posture toward mobilizing these funds is vital for the development of adequate resources in the community for the chronically mentally ill. In the absence of reliable data, however, we have chosen not to attempt to estimate housing expenditures by public agencies for the chronically mentally ill.

*Veterans Administration*. The VA system delivers a substantial amount of mental health care. The VA Boston Development Center provided information regarding the amount spent for inpatient and outpatient care in the Veterans Adminstration hospitals in Texas. Inpatient expenditures for persons with diagnoses of psychoses, childhood mental disorders, or other diagnoses of mental disorders amounted to $13.1 million in 1987. Eleven million dollars were spent in that same year to treat outpatients with a middle or high level of psychiatric service utilization. Mid-level psychiatric care utilization is defined as having a minimum of four treatment visits during fiscal year 1987. High utilization is determined for individuals having a minimum of seven psychiatric care visits during that same period.

*Food Stamps*. With regard to food stamps, any single Texan whose income is less than $459 per month is eligible for food stamps. As of July 8, 1988, the average food stamp benefit for a one-person household in Texas was $49.88 per month. We assumed that 30,000 chronically mentally ill persons currently are receiving the average benefits. This amounts to $17.956 million annually. The rationale for using 30,000 was that it roughly is equivalent to the sum of SSI and SSDI recipients that we estimate are chronically mentally ill.

*Training Programs*. Training programs may be linked to the service delivery program of the Community Mental Health Center, but more commonly they are funded by the Texas Rehabilitation Commission (TRC). Since training is a mutual responsibility, some of the funds discussed in this section may be accounted for already in the CMHC section. For participation in the commission's vocational rehabilitation program, a counselor must confirm the existence of a disability. The two requirements necessary for inclusion are the existence of a disability and a reasonable expectation for rehabilitation. In 1987, other mental illness was the category that accounted for the highest percentage (15) of clients served by vocational rehabilitation. Only a portion of that population can be

considered to be chronically mentally ill. That same year, psychosis accounted for 4 percent of the clients served. During the first nine months of fiscal year 1988, there were 1,187 persons with a diagnosis of psychosis, 3,306 with a diagnosis of psychoneurosis, and 1,816 with a diagnosis of other mental disorders deemed eligible for vocational rehabilitation and receiving services. We used an estimate of 5 percent chronically mentally ill because it appears that many in the other mental illness category are not severely or chronically mentally ill. Our estimate of $3,316,084 spent on the chronically mentally ill for vocational rehabilitation in 1987 is based on taking 5 percent of the total vocational rehabilitation budget of TRC of $66.3 million for 1987.

*Income Support Programs*. Income support programs for the non-aged chronically mentally ill are primarily state or federal entitlement programs for the disabled. A person is certified as disabled by the Texas Rehabilitation Commission. The disability determination is based on Social Security regulation and medical criteria. Medical evidence (i.e., clinical signs, symptoms, and/or laboratory psychological test findings) must be presented to determine the existence of a medically determinable impairment. Depending on income and work history, the individual is deemed eligible for Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or neither. In 1986 a disabled person whose income was less than $336 per month was eligible for SSI (State Medicaid Information Center of National Governors' Association, 1986). The midpoint SSI payment is $177. States have the option of supplementing the federal SSI payments. Texas is one of the few states which has chosen not to supplement. If persons receive SSI, they become automatically eligible for Medicaid.

If persons have worked and have paid Social Security taxes for a determined length of time when they are found to be disabled, they will be eligible for SSDI. The standards for disability due to mental impairment for SSDI were changed in 1984, making it more accessible to persons with serious mental illnesses (Vischi, 1988). Five months after onset of disability, eligibility begins, and individuals begin to receive their SSDI payment. It may be large enough to knock them off SSI and also, of course, off Medicaid. The person covered by SSDI becomes eligible for Medicare after having received SSDI for 24 months during the past five years (Vischi, 1988). Medicare has its own set of benefits and limitations and is generally more demanding of beneficiary payment of deductibles and copayments.

The Dallas Regional Social Security Office estimates that in December 1986 there were 123,206 blind and disabled SSI recipients in Texas.

Nationally, mental disorder accounts for 22.6 percent of SSI recipients, according to the Regional Social Security Office. If these figures are correct, then there were 27,845 SSI recipients with mental disease in Texas in 1986. Since the average SSI payment is $177.00 per month, we estimate that $59.1 million was paid in SSI benefits to individuals with mental disease in 1986.

Our estimates of SSDI expenditures for the chronically mentally ill are based on a figure of 122,000 persons on SSDI in Texas in 1987. Of those individuals, 18.6 percent or 22,692 persons have a mental health diagnosis. We assume 25 percent or 5,673 of these are chronically mentally ill. Information from the Social Security Administration shows the average monthly benefit in 1987 for recipients with a mental health diagnosis to be $473.10 (Hoover, 1988). Most chronically mentally ill individuals have poor work histories, thus lowering the level of SSDI payment. The total annual expenditure for SSDI for the chronically mentally ill is estimated to be 32.2 million (Archuleta, 1988).

*Other Direct Costs of Mental Illness*

The totals in Table 1 are, of course, speculative. In any case, the total level of local, state, and federal funding for both the mentally ill and the chronically mentally ill in Texas is substantial. Significant expenditures through private insurance, private resources, and charitable care for this population are outside the scope of this paper.

In addition, enormous burdens are put on families to care for the chronically mentally ill. With the push for deinstitutionalization of severely and chronically mentally ill individuals, the burden of caring for patients with chronic schizophrenia and affective disorders has shifted from hospitals to the family and other community-based agencies (Liberman, 1988, p. 204). It has been estimated that 70 percent of the severely mentally ill patients have family members who can or will be involved after hospitalization (Chacko, 1985, p. 6).

Taken together, all of the governmental and charitable resources spent on the chronically mentally ill in 1987 in Texas probably amounted to at least $500 million and possibly more. Including family resources devoted to the care of this population increases these estimates substantially. These expenditures of time and money represent a major cost to society and yet also provide an incentive to develop programs which will improve the lives of the chronically mentally ill, while possibly reducing costs.

## Potential Changes in Financing and Costs

In response to the *R.A.J. v. Miller* lawsuit, TDMHMR developed an incentive payment system for community centers and state outreach

programs. Recently state centers have become eligible for the payments as well. The program was developed to encourage community centers to develop community-based programs and to reward them for reducing utilization of the state hospitals from their catchment area. The idea was to meet court-mandated staffing patterns at the state hospitals by reducing patients rather than hiring additional staff (Legislative Budget Board, 1988, p. 188). Currently,

> the amount of the payment is calculated by comparing the adjusted FY 1983 baseline and incentive baseline number of bed days used by clients during the preceding month/quarter. If the number of bed days is below the adjusted FY 1983 baseline, the mental health authority receives reimbursement equal to $35.50 times the difference between the adjusted baseline and the actual bed days used down to the incentive baseline. For bed day utilization below the incentive baseline, the mental health authority receives payments of $35.50, $45 or $60, depending upon bed day utilization per 100,000 population. (Suehs, 1987)

Concurrently, utilization at the state mental hospitals in Texas has declined dramatically. Between 1984 and 1987, the average daily census at the state hospitals declined by almost 10 percent per year (Texas Department of Mental Health and Mental Retardation, 1988, p. 23).

In determining whether the $35.50 program, as it is called, is cost-effective, the problem lies in knowing the status of the clients who are no longer in the state mental hospitals. If the cost to the state is the same, then the question is whether the clients are as well treated, well housed, well clothed, and independent under the $35.50 program as they were in the state hospital. A confounding factor to the analysis, of course, is the issue of whether the $35.50 funds also are expanding services to other chronically mentally ill persons who were not hospitalized and who now have more services.

The program most commonly identified for expansion in Texas is the Medicaid program. Although Texas is one of the few states that does not supplement SSI payments, the expansions most generally discussed do not involve expanding the eligibility pool. Rather, in general the expansions have centered on adding optional services to the program. Touche Ross, in a consultation to TDMHMR, recommended that the highest return to the state could come in adding coverage for the population above 65 who were in institutions for mental disease (IMD) and coverage for diagnostic, screening, and rehabilitation services, including evaluation/assessment services, psychotherapy services, and medication services. In each case the consultants proposed strong controls on the services so that little of the increased funding would go outside the state hospitals and community centers (Touche Ross, 1987).

The motivation for expanding Medicaid is, of course, fiscal. If Medicaid funding were effective October 1, 1988, a 59 percent federal match for

Texas could be substituted for 100 percent state funding of programs. This change clearly would be a substantial savings to the state. These proposals were built on earlier proposals developed in a report to the lieutenant governor in 1985 (Texas Department of Human Resources and Texas Department of Mental Health and Mental Retardation, 1985).

TDMHMR currently has put the proposal to pay for persons above 65 in IMDs on hold. It actively is pursuing payment for case management services and coverage for diagnostic, screening, and rehabilitation services as described above (Russell, 1988). Enrolling the Community Center pharmacies in the Medicaid vendor drug program is under active consideration, also. In general, most potential expansions are examined primarily from the point of view of whether they will save the state money. Also, there may be potential for some of the strictly local funds in the hospital districts to be matched into programs which would help reduce the number and costs of crisis admissions through the emergency rooms.

It would be helpful to look at the benefits accrued to the chronically mentally ill population from services in the private sector if Medicaid expansion were to take place. Although this might have less clear-cut fiscal advantages to the state government, it would be important from the point of view of society at large.

With regard to Medicaid, one suggestion made to us was that the legislature appropriate the TDMHMR budget based on a certain amount of state funding and some Medicaid reimbursement. If TDMHMR managed to acquire more Medicaid reimbursement, it would be able to keep it and enhance its budget rather than all the funds going to the General Fund, as currently happens. By being at risk, TDMHMR presumably would be more aggressive in seeking to maximize Medicaid reimbursement.

The emerging consensus in mental health circles is that community-based care can and should be substituted extensively for institutional care. In fact, several manuals have been published that provide hands-on instruction regarding how financing for these enhanced services can be arranged (Craig & Wright, 1988; Vischi, 1988). Clearly, extension of the case management option under Texas Medicaid will be helpful here, but housing, training, and income support will be important also.

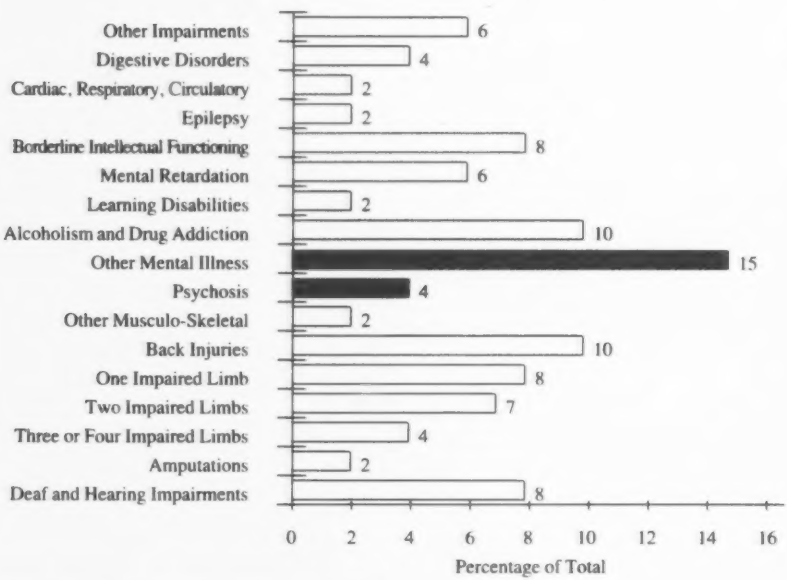
Community-based care has become the watchword of other groups dependent on Medicaid or state funds for long-term institutional care. It has been contended that more aggressive case management of the elderly in nursing homes could lead to less expensive treatment in the person's home with some community support. Most studies have not been able to document these savings, since enhanced services also tend to emerge from these initiatives. One recent study found that high-risk elderly people living in community housing with case-managed care had significantly shorter stays than those without such support. For lower risk elderly

persons, case-managed care made no or little difference in utilization (Morris, Gutkin, Ruchlin, & Sherwood, 1987). This is not to say that the services to the high-risk individuals are necessarily less expensive, but they do at least have an impact.

The development of community care for the chronically mentally ill also should be targeted to persons for whom the program will be effective. This should be measured not only in terms of the extent of improvement of the client but also in terms of the savings in reduction of institutionalization. With the chronically mentally ill, many clients have the capacity to be in the work force and contribute to their own support. To the extent that this can be achieved, the calculus of cost justification is even easier to make.

For Texas, it is important initially that programs be developed so that enhanced federal funds be generated to match the state and local funds already being spent in the mental health system. As the share of federal funds becomes more like the national ratios, it will then become vital that these enhanced resources be devoted to developing programs that improve community care. Cost cannot be the only criterion. The well-being of the population being served must enter the calculations as well.

*Figure A-1*. Primary Disabilities of Vocational Rehabilitation Clients Served by the Texas Rehabilitation Commission




*Source:* Legislative Budget Board (1988, p. 124).

**Table A-1**

Appropriations to Texas Department of Mental Health and Mental Retardation Mental Health Services

| | Budgeted 1987 | Budgeted 1988 | Percent change 1987–88 | Budgeted 1989 | Percent change 1988–89 |
|---|---|---|---|---|---|
| 1. Program administration (MH) | $1,062,158 | $1,030,293 | −3% | $1,030,293 | 0% |
| 2. State mental hospitals | | | | | |
| a. Campus-based residential treatment and habilitation | $112,773,204 | $106,294,379 | −6% | $102,294,440 | −4% |
| b. Facility management and support | 42,065,204 | 42,545,363 | 1% | 42,751,567 | 0% |
| c. Utilities (nontransferable) | 9,776,896 | 9,776,896 | 0% | 9,776,896 | 0% |
| d. Community services | 16,274,799 | 17,774,799 | 9% | 17,774,799 | 0% |
| 3. Harris County Psychiatric Center | 14,690,000 | 18,198,382 | 24% | 18,198,382 | 0% |
| Subtotal, state hospitals | $195,580,103 | $194,589,819 | 0% | $190,796,084 | −2% |
| 4. State centers (mental health) | | | | | |
| a. Campus-based residential treatment and habilitation | $4,053,237 | $3,879,341 | −4% | $3,879,341 | 0% |
| b. Facility management and support | 1,493,031 | 1,493,031 | 0% | 1,493,031 | 0% |
| c. Utilities | 349,367 | 349,367 | 0% | 349,367 | 0% |
| d. Community services | 1,869,618 | 2,176,358 | 16% | 2,436,758 | 12% |
| Subtotal, centers | $7,765,253 | $7,898,097 | 2% | $8,158,497 | 3% |
| 5. Contracted community services—mental health | | | | | |
| a. Residential services | $20,463,878 | $30,821,824 | 51% | $34,662,389 | 12% |
| b. Client and family support | 36,317,566 | 39,374,681 | 8% | 44,191,660 | 12% |
| c. Case management | 6,152,132 | 7,483,808 | 22% | 8,405,978 | 12% |
| d. Management and support | 9,393,434 | 9,393,434 | 0% | 9,393,434 | 0% |
| e. Tarrant County Psychiatric Hospital | 949,888 | 3,285,576 | 246% | 3,285,576 | 0% |
| 6. Staff-to-patient ratios: mental health | $1,246,146 | $9,328,064 | 568% | $11,697,015 | 40% |
| 7. Staff-to-patient ratios: substance abuse | $0 | $6,568,723 | | $6,568,723 | 0% |
| Total | $278,930,558 | $308,774,319 | 11% | $318,189,649 | 3% |

*Source:* Senate Bill Number 1, General Appropriation Bill for 1988–89 Fiscal Year, 70th Legislature. Texas Department of Mental Health and Mental Retardation, Operating Plan, FY 1988, p. 8.

Table A-2

Percentage of Population Designated as Chronically Mentally Ill in Texas State Mental Hospitals

| | Principle psychiatric diagnosis by length of stay | | | | |
|---|---|---|---|---|---|
| | 30 days or less | 31–90 days | 91–365 days | One year or more | Total |
| Schizophrenia and related disorders | 1,337 | 1,561 | 963 | 291 | 4,152 |
| Other organic disorders | 179 | 178 | 137 | 106 | 600 |
| Subtotal, chronically mentally ill | 1,516 | 1,739 | 1,100 | 397 | 4,752 |
| Subtotal, CMI bed days[a] | 22,740 | 104,340 | 250,800 | 144,905 | 522,785 |
| Total, all psych. diagnoses | 8,495 | 4,904 | 2,288 | 596 | 16,283 |
| Total bed days[a] | 127,425 | 294,240 | 521,664 | 217,540 | 1,160,869 |
| Percent CMI days of total | 17.8% | 35.5% | 48.1% | 66.6% | 45.0% |

*Source:* Texas Department of Mental Health and Mental Retardation, Data Book 1986, Vol. A, Discharges, September 1, 1985–August 31, 1986, p. 41.

[a] When figuring number of bed days, we used, as the length of stay, the midpoints for each range and 365 for anything over one year.

Table A-3

Community Mental Health Center Expenditures by Program Category for FY 1987—Mental Health

| | Center Adminstration | MH Residential Services | MH Nonresidential Services | Case Management | Continuity of Care | Total |
|---|---|---|---|---|---|---|
| 1. Abilene | $ 357,627 | $ 435,188 | $ 799,354 | $ 268,989 | $ 27,486 | $ 1,888,644 |
| 2. Austin–Travis | 1,113,528 | 2,313,506 | 2,872,760 | 300,507 | 169,179 | 6,769,480 |
| 3. Bexar County | 693,229 | 3,330,122 | 4,100,631 | 605,429 | 92,963 | 8,822,374 |
| 4. Brazos Valley | 214,164 | 391,744 | 649,679 | 90,433 | 135,229 | 1,481,249 |
| 5. Central Counties | 405,680 | 712,258 | 1,470,487 | 241,843 | 25,284 | 2,855,553 |
| 6. Central Plains | 251,332 | 771,596 | 430,437 | 80,557 | 4,372 | 1,538,293 |
| 7. Central Texas | 227,341 | 166,066 | 526,018 | 121,952 | 20,166 | 1,061,542 |
| 8. Concho Valley | 84,327 | 203,838 | 575,556 | 107,883 | 16,123 | 987,727 |
| 9. Dallas County | 1,130,308 | 5,781,630 | 6,430,283 | 473,399 | 340,185 | 14,155,804 |
| 10. Deep East Texas | 403,535 | 1,681,104 | 1,091,027 | 194,693 | 0 | 3,370,359 |
| 11. East Texas | 517,612 | 617,227 | 1,960,135 | 92,781 | 144,105 | 3,331,859 |
| 12. Gulf Bend | 137,931 | 435,977 | 931,029 | 95,621 | 5,806 | 1,606,364 |
| 13. Gulf Coast | 381,013 | 411,814 | 1,495,947 | 148,007 | 177,164 | 2,613,945 |
| 14. Harris County | 2,126,029 | 7,769,589 | 10,564,403 | 658,529 | 371,650 | 21,490,199 |
| 15. Heart of Texas | 392,851 | 489,313 | 1,420,620 | 207,601 | 0 | 2,510,384 |
| 16. Johnson County | 91,838 | 0 | 163,901 | 24,395 | 25,343 | 305,476 |
| 17. Life Management | 493,086 | 754,135 | 2,356,981 | 273,842 | 66,215 | 3,944,260 |
| 18. Lubbock | 248,841 | 916,929 | 1,078,677 | 345,703 | 85,056 | 2,675,206 |
| 19. Navarro County | 51,558 | 21,482 | 302,680 | 30,252 | 0 | 405,972 |
| 20. Northeast Texas | 98,708 | 165,196 | 641,290 | 71,216 | 32,048 | 1,008,457 |
| 21. Nueces County | 266,016 | 1,281,609 | 1,135,580 | 112,543 | 77,807 | 2,873,554 |
| 22. Pecan Valley | 161,850 | 253,832 | 933,939 | 206,752 | 38,837 | 1,595,210 |
| 23. Permian Basin | 267,231 | 422,169 | 1,276,411 | 59,263 | 36,917 | 2,061,990 |
| 24. Sabine Valley | 250,773 | 1,602,417 | 1,644,411 | 238,706 | 0 | 3,736,307 |
| 25. Southeast Texas | 262,060 | 2,479,172 | 1,861,993 | 140,139 | 15,320 | 4,758,684 |
| 26. Tarrant County | 702,508 | 1,141,906 | 3,429,189 | 194,097 | 158,879 | 5,626,578 |
| 27. Texas Panhandle | 212,149 | 1,156,527 | 1,486,996 | 177,048 | 0 | 3,032,720 |
| 28. Texoma | 202,690 | 308,020 | 1,121,811 | 80,980 | 26,474 | 1,739,975 |
| 29. Tri-County | 359,279 | 755,736 | 1,634,448 | 147,874 | 8,358 | 2,905,696 |
| 30. Tropical Texas | 673,585 | 735,229 | 2,365,662 | 144,510 | 86,514 | 4,005,500 |
| 31. Wichita Falls | 212,390 | 191,443 | 914,779 | 162,805 | 18,738 | 1,500,155 |
| Total | $12,991,062 | $37,696,774 | $57,667,114 | $6,098,347 | $2,206,219 | $116,659,516 |

*Source.* Austin–Travis County MHMR Center, Summary Data Book for Community MHMR Centers for the Fiscal Year Ending August 31, 1987, p. 6.

**Table A-4**

Community Mental Health Centers Revenue Totals for FY 1987

| | Local Tax Revenue | Patient Fees | Other Local Revenue | General Revenue | MH Block Grant | Staff-to-Patient MH | Other State | Other Federal | Total |
|---|---|---|---|---|---|---|---|---|---|
| 1. Abilene | $ 131,750 | $ 223,252 | $ 332,246 | $ 1,122,275 | $ 29,651 | $ 63,900 | $ 409,414 | $ 157,085 | $ 2,469,573 |
| 2. Austin—Travis | 2,196,090 | 638,239 | 1,188,319 | 3,901,285 | 235,519 | 667,081 | 1,170,024 | 556,147 | 10,552,704 |
| 3. Bexar County | 1,724,175 | 498,245 | 1,000,177 | 6,533,380 | 170,655 | 906,031 | 860,134 | 189,282 | 11,882,079 |
| 4. Brazos Valley | 147,843 | 96,401 | 243,293 | 1,309,312 | 143,077 | 19,575 | 275,064 | 202,269 | 2,436,834 |
| 5. Central Counties | 357,000 | 287,796 | 312,637 | 1,950,446 | 513,539 | 430,438 | 214,353 | 141,668 | 4,207,877 |
| 6. Central Plains | 42,789 | 290,892 | 477,238 | 1,050,666 | 27,944 | 359,402 | 118,549 | 157,223 | 2,524,703 |
| 7. Central Texas | 13,300 | 144,367 | 964,203 | 836,933 | 406,477 | 68,125 | 154,332 | 72,850 | 2,660,587 |
| 8. Concho Valley | 116,629 | 155,608 | 299,843 | 788,027 | 20,753 | 36,459 | 152,683 | 109,864 | 1,679,866 |
| 9. Dallas County | 4,028,565 | 739,403 | 1,210,533 | 9,371,145 | 299,098 | 1,457,240 | 1,271,824 | 543,248 | 18,921,056 |
| 10. Deep East Texas | 124,689 | 1,197,670 | 1,073,506 | 1,833,077 | 460,203 | 829,610 | 695,174 | 256,733 | 6,470,622 |
| 11. East Texas | 106,800 | 1,253,701 | 639,603 | 1,843,020 | 48,368 | 848,415 | 731,106 | 261,335 | 5,732,348 |
| 12. Gulf Bend | 56,838 | 299,860 | 287,180 | 1,019,648 | 26,695 | 302,069 | 47,646 | 83,884 | 2,123,820 |
| 13. Gulf Coast | 356,908 | 179,214 | 1,580,046 | 2,419,745 | 63,054 | 142,144 | 30,980 | 432,369 | 5,204,460 |
| 14. Harris County | 12,444,969 | 275,579 | 817,572 | 12,480,679 | 1,162,742 | 662,714 | 514,866 | 963,054 | 29,322,175 |
| 15. Heart of Texas | 243,493 | 129,974 | 590,183 | 1,896,908 | 293,914 | 308,318 | 406,070 | 309,317 | 4,178,177 |
| 16. Johnson City | 85,000 | 28,789 | 173,739 | 118,845 | 175,000 | 31,666 | 42,018 | 19,826 | 674,883 |
| 17. Life Management | 169,666 | 595,380 | 1,268,015 | 2,767,908 | 171,174 | 358,586 | 344,504 | 250,791 | 5,926,024 |
| 18. Lubbock | 0 | 731,854 | 931,571 | 1,777,573 | 46,699 | 377,436 | 122,986 | 372,063 | 4,360,182 |
| 19. Navarro County | 12,500 | 14,540 | 53,121 | 284,857 | 7,520 | 154,461 | 11,500 | 0 | 538,499 |
| 20. Northeast Texas | 31,870 | 91,638 | 235,014 | 832,950 | 21,855 | 302,638 | 11,500 | 40,300 | 1,567,765 |
| 21. Nueces County | 295,554 | 85,704 | 546,892 | 2,921,777 | 78,674 | 141,148 | 240,162 | 263,166 | 4,573,077 |
| 22. Pecan Valley | 48,060 | 128,375 | 407,436 | 825,159 | 652,988 | 318,045 | 189,511 | 72,502 | 2,642,076 |
| 23. Permian Basin | 278,918 | 191,862 | 534,435 | 1,781,742 | 80,948 | 0 | 310,151 | 221,256 | 3,399,312 |
| 24. Sabine Valley | 214,338 | 560,226 | 1,527,271 | 1,234,088 | 651,142 | 780,253 | 822,287 | 160,075 | 5,949,680 |
| 25. Southeast Texas | 273,800 | 339,454 | 630,963 | 2,179,870 | 93,465 | 569,451 | 1,465,338 | 29,708 | 5,582,049 |
| 26. Tarrant County | 847,222 | 957,668 | 738,356 | 4,915,947 | 210,492 | 541,730 | 166,408 | 798,844 | 9,176,667 |
| 27. Texas Panhandle | 48,997 | 123,949 | 440,626 | 1,905,164 | 89,695 | 688,380 | 56,571 | 0 | 3,353,382 |
| 28. Texoma | 109,402 | 136,862 | 440,600 | 1,048,527 | 558,069 | 431,005 | 83,785 | 128,035 | 2,936,285 |
| 29. Tri-County | 272,866 | 333,479 | 2,177,095 | 1,853,513 | 137,582 | 541,946 | 80,300 | 140,159 | 5,536,940 |
| 30. Tropical Texas | 200,549 | 360,370 | 1,276,085 | 2,984,780 | 737,311 | 5,325 | 496,895 | 579,670 | 6,640,985 |
| 31. Wichita Falls | 189,300 | 182,886 | 625,317 | 1,095,451 | 29,150 | 603,997 | 41,183 | 61,650 | 2,828,934 |
| Total | $25,169,880 | $11,273,237 | $23,023,115 | $76,884,697 | $7,643,453 | $12,947,588 | $11,537,318 | $7,574,373 | $176,053,661 |

*Source:* Austin—Travis County MHMR Center, Summary Data Book: For Community MHMR Centers: For the Fiscal Year Ending August 31, 1987, pp. 2–3.

Table A-5

Medicaid Expenditures for Severe Psychiatric Diagnoses at Texas Acute Care Hospitals—1987

| Diagnosis related group | Number of claims | Billed amount | Other insurance | DRG payment |
|---|---|---|---|---|
| 430 Psychoses | 3,279 | $11,674,524 | $113,787 | $5,996,708 |
| 431 Childhood mental disorders | 178 | $993,974 | $34,458 | $515,081 |
| 432 Other diagnoses of mental disorders | 9 | $176,974 | $0 | $22,939 |
| Total | 3,466 | $12,845,472 | $148,245 | $6,534,728 |

*Source:* Texas Hospital Association's Technical Advisory Group analysis of 1987 costs and payments under prospective payment.

Table A-6

Clients in Vocational Rehabilitation at Texas Rehabilitation Commission According to Primary Disability Classification

| | FY 1987 | FY 1988 to present |
|---|---|---|
| Psychosis | | |
| Referral | 1,423 | 1,344 |
| Accepted as eligible | 945 | 856 |
| Evaluating | 354 | 477 |
| Rehabilitated | 505 | 400 |
| Closed unsuccessfully | 390 | 266 |
| Eligible, receiving services | 976 | 1,187 |
| Psychoneurosis | | |
| Referral | 3,332 | 2,845 |
| Accepted as eligible | 2,396 | 2,012 |
| Evaluating | 780 | 962 |
| Rehabilitated | 1,325 | 1,025 |
| Closed unsuccessfully | 683 | 516 |
| Eligible, receiving services | 2,860 | 3,306 |
| Other mental disorders | | |
| Referral | 2,243 | 1,562 |
| Accepted as eligible | 1,546 | 1,089 |
| Evaluating | 468 | 462 |
| Rehabilitated | 824 | 635 |
| Closed unsuccessfully | 475 | 358 |
| Eligible, receiving services | 1,733 | 1,81[illegible] |

*Source:* Texas Rehabilitation Commission, Disability Report by State Summary Report, October 2, 1987, and July 2, 1988.

Table A-7

Medicare Recipient Information Based on Admissions to Texas Hospitals

| Primary diagnosis | Total admissions | Total reviews | Total deaths | Total denials |
|---|---|---|---|---|
| 294.0 | 14 | 0 | 0 | 0 |
| 294.1 | 74 | 14 | 1 | 2 |
| 294.8 | 146 | 32 | 1 | 1 |
| 294.9 | 133 | 28 | 2 | 2 |
| 296.7 | 158 | 19 | 0 | 1 |
| 296.80 | 47 | 3 | 0 | 0 |
| 296.81 | 17 | 2 | 0 | 0 |
| 296.82 | 98 | 18 | 0 | 0 |
| 296.89 | 11 | 2 | 0 | 0 |
| 296.90 | 73 | 14 | 1 | 1 |
| 296.99 | 16 | 4 | 0 | 0 |
| 297.0 | 5 | 2 | 0 | 0 |
| 297.1 | 55 | 9 | 1 | 0 |
| 297.2 | 15 | 1 | 0 | 0 |
| 297.3 | 4 | 1 | 0 | 0 |
| 297.8 | 7 | 0 | 0 | 0 |
| 297.9 | 144 | 20 | 0 | 0 |
| 298.0 | 34 | 4 | 0 | 1 |
| 298.1 | 53 | 13 | 0 | 1 |
| 298.2 | 7 | 1 | 0 | 0 |
| 298.3 | 44 | 5 | 0 | 0 |
| 298.4 | 1 | 0 | 0 | 0 |
| 298.8 | 51 | 10 | 0 | 0 |
| 298.9 | 765 | 96 | 23 | 5 |
| Totals | 1,972 | 298 | 29 | 14 |

*Source:* Texas Medical Foundation, based on hospital admissions March 1, 1987–February 29, 1988.

Table A-8

Veterans Administration Psychiatric Costs, Inpatient and Outpatient, 1987

| | | |
|---|---|---|
| Inpatient expenditures by DRG | | |
| 430 Psychoses | $13,026,242 | |
| 431 Childhood mental disorders | 42,026 | |
| 432 Other diagnoses of mental disorders | 58,684 | |
| Total | | $13,126,952 |
| Outpatient expenditures | | |
| Mid psych patients[a] | 2,237,018 | |
| High psych patients[b] | 8,859,000 | |
| Total | | 11,096,018 |
| Total | | 24,222,970 |

*Source:* Steven Kendall, Boston Development Center, October 3, 1988.

[a] "Mid psych" represents a minimum of four visits.

[b] "High psych" represents a minimum of seven visits.

Table A-9

Psychiatric Inpatient Days, 1986, Texas Public Hospitals

| | Acute care inpatient days | Long-term care inpatient days |
|---|---|---|
| Ben Taub General Hospital | 10,280 | 0 |
| Bexar County Hospital District | 7,952 | 0 |
| Citizens Medical Center | 7,623 | 0 |
| John Peter Smith Hospital | 12,299 | 0 |
| Memorial Medical Center | 14,111 | 0 |
| Parkland Memorial Hospital | 6,163 | 0 |
| R. E. Thomason General Hospital | 0 | 0 |
| Total | 58,428 | 0 |
| Total expenditure[a] | $36,984,924 | $0 |

*Source:* Texas Department of Health, Bureau of State Health Data and Policy Analysis, July 22, 1988.

[a] Based on an average public hospital expenditure of $633 per patient day.

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# State Hospital Reform in Texas: A History of the *R.A.J.* Class Action Lawsuit

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## Introduction

The *R.A.J.* class action lawsuit against Texas Department of Mental Health and Mental Retardation (TDMHMR) is aimed at the institutional reform of the eight state hospitals. This case was filed in United States District Federal Court in 1974 by the parents of patients in several of the hospitals. Plaintiffs, represented by Legal Services of North Texas, alleged that the constitutional rights of the involuntarily committed patients were being violated. Although the case was filed in 1974, movement did not really take place until reviews of the hospitals were conducted in 1980 by experts representing the U.S. Department of Justice, which had entered the case as amicus curiae. At this point the plaintiffs, defendents, and amicus curiae negotiated a settlement agreement which was aimed at alleviating the conditions identified in the experts' reports.

This paper will relate the legal issues involved in institutional reform litigation, will describe the requirements of the *R.A.J.* settlement agreement, and then will examine the implementation phase of the case from April 1982 through June 1988.

## Development of the *R.A.J.* Settlement Agreement

The legal issues which gave the federal court jurisdiction over the operation of state mental hospitals were defined in the 1960s and 1970s and were a side effect of the civil rights movement (McPheeters, 1980). The first case that began to establish a constitutionally determined right to treatment of a mental patient in a psychiatric hospital was *Rouse v. Cameron* (Weiner, 1985). This case questioned the comparability between criminal commitment to a correctional institution and civil commitment to a psychiatric hospital. The question was whether the due process rights of an individual were honored if the person did not receive active treatment. Commitment without treatment was compared to criminal incarceration without a trial. Lack of treatment in a psychiatric hospital was considered to be so inhumane as to be cruel and unusual punishment (Weiner, 1985). In 1972 *Wyatt v. Stickney* produced a ruling in federal district court that

held that there were constitutionally based rights to treatment for involuntarily civilly committed patients, and the court determined minimal standards of care that were aimed at defining a humane psychological and physical environment, adequate staffing to provide adequate treatment, and individualized treatment plans (Kopolow, Brands, Burton, & Ochberg, 1975; Weiner, 1985). Although the *Wyatt v. Stickney* case established the right to treatment, it did not clearly delineate the judicial basis for such a right (Weiner, 1985). This was done in 1974 when the U.S. Court of Appeals for the Fifth Circuit decided *O'Connor v. Donaldson* (Weiner, 1985). In lengthy litigation which examined the legality of the patient's involuntary commitment the court of appeals established that there was a right to treatment based on protections of the Fourteenth Amendment guaranteeing that the loss of liberty would not occur without the exercise of due process rights. Therefore, a person could not be committed to a psychiatric institution without the provision of treatment (Weiner, 1985).

The concept of the right to treatment in the least restrictive environment was defined in *Welsh v. Likens* and *Halderman v. Penhurst*, which concerned the mentally retarded in state schools. The *Welsh v. Likens* ruling substantiated the right to treatment and maintained that it was a responsibility of state officials to seek the least restrictive alternative for treatment. In the *Penhurst* litigation there was a definite push to provide services outside of institutions since it had been argued in this case that minimally adequate habilitation could not be provided in an institutional setting (Weiner, 1985). This litigation was focused on the development of community services as an alternative to institutional care.

In 1982 the Supreme Court made a ruling in *Youngberg v. Romeo* which restricted the interpretation of the standard of right to treatment (Weiner, 1985). The Court concluded that an individual in a state institution did not have an absolute right for treatment but rather should be protected from harm, should not be caused to deteriorate in condition, and should be subject to treatment based on the judgment of a qualified professional. Since 1982 the *Romeo* standards of protection from harm and the presumed validity of professional judgment have become the standards for interpreting the level of care required in state institutions.

The original compaint in the *R.A.J.* litigation alleged that patients in the state hospitals were having their constitutional rights violated in that they were not receiving active treatment, they were being exposed to overuse and misuse of psychotropic medications, and they were being exposed to unsafe living conditions. The discovery conducted by the experts for the United States Department of Justice presented reports which might have substantiated these allegations. The case, however, did not go to trial but was settled out of court through the negotiation of a settlement agreement which contained requirements which were aimed at addressing the

identified problems. The settlement agreement (*R.A.J. v. Miller, Settlement Agreement*, 1981) specified the following:

- ☐ Protection of patients' rights.
- ☐ Provision of individualized treatment planning and programming aimed at addressing the problems which necessitated hospitalization.
- ☐ Adequate staffing to provide 30 hours of appropriate programming to patients.
- ☐ Renovation of buildings to meet fire and safety standards.
- ☐ Development of guidelines for the appropriate provision of psychotropic medications.
- ☐ Development of policy which would permit involuntary patients to refuse psychotropic medications.
- ☐ Definition of appropriate care and treatment of mentally retarded clients in the state hospitals, which included the development of specialized treatment programs for the mentally retarded patients who needed psychiatric inpatient treatment.
- ☐ Placement of clients with mental retardation who no longer needed psychiatric hospitalization into appropriate MR programs.
- ☐ Accreditation of the state hospitals by the Joint Commission on Accreditation of Hospitals (JCAH).
- ☐ Development of specialized programs for geriatric patients.
- ☐ Development of specialized treatment programs for the adult general psychiatric population.
- ☐ Development of aftercare plans for patients discharged from the hospitals and a system of community support programs for these patients.
- ☐ Seeking of appropriate funding from the legislature for implementation of these improvements.

An administrative requirement of this settlement agreement was the establishment of a three-person panel to monitor defendants' compliance with the requirements of the lawsuit. The panel was to have access to financial, personnel, staffing, and client records and other records relevant to compliance issues and was to monitor on a regular basis and report to the court every six months concerning compliance with the lawsuit. Initially it was envisioned that compliance would take approximately three years and the panel was established in April 1982 for that time period. The panel consisted of David Pharis, a psychiatric social worker, as the coordinator and full-time member and Dr. James Peden, a psychiatrist, and Martha Boston, an attorney, as the two part-time members. The life of the panel has been extended by the court several times since 1985.

Implementation of the Requirements of the *R.A.J.* Settlement Agreement

*April 1982 through April 1983*. Defendents' action plan. Guidelines for the appropriate use of psychotropic medications.

The settlement agreement was approved by the court in April 1981. The appointment of the panel in April 1982 began the formal implementation period for defendants to meet the requirements of the settlement agreement. However, during the year between the settlement agreement's approval and the appointment of the panel, defendants had established an action plan for meeting the requirements of the settlement agreement. One of the first actions of the panel was to review this plan (*R.A.J. v. Miller, Review Panel Recommendations 1–21*, 1982).

The review panel was concerned that the plan was predominately a plan to plan, focusing on process rather than on result. Although many of the sequential process activities were appropriate, there seldom was a concluding end product which could be considered the desired result of the compliance effort.

The panel also was concerned that the implementation plan had not specifically addressed how the sections of the plan would be funded. It was not clear how specific compliance areas would be dealt with in the 1984 legislative budget request and also it was not clear whether the defendants intended to reallocate existing resources if there was a need to do so in order to implement the various requirements of the agreement.

The review panel's recommendations prompted a series of meetings to discuss how the TDMHMR would respond. Agreements were reached between the panel and the parties on individual topics such as protection of patients' rights, the implementation of fire safety code renovations, and so forth, with new time frames for the revised plans. In retrospect the panel's criticisms of the defendants' plan had the effect of fragmenting the plan. What had been a uniformly conceived plan, albeit a plan to plan, became somewhat uncoordinated specific issues. This has contributed to a somewhat incremental approach to implementation which is probably a realistic approach given the scope of the compliance issues.

Another issue that the parties had negotiated prior to the appointment of the review panel was the development of standards and guidelines for the appropriate use of psychotropic medications. These negotiations were conducted primarily between defendants' psychiatric consultants and a consultant for the U.S. Department of Justice. In the fall of 1982 a draft policy was presented to the TDMHMR commissioner for approval. The commissioner did not approve the document and expressed his opposition to many of the principles of the policy. This opposition to the policy caused

the negotiation process to break down temporarily. In the late fall of 1982, the review panel, which up to this point had not been involved in negotiations between the parties, made a formal recommendation to the court that the medication policy developed through the negotiation process be adopted by the court as the policy which would meet the requirements of the settlement agreement. Since the commissioner already had opposed the adoption of the policy, the defendants objected to the approval of the policy but began to involve themselves again in the negotiation process to develop an acceptable policy. The review panel entered into the negotiation process at this point, and in February 1983 a "Supplemental Agreement Regarding the Appropriate Use of Psychotropic Medications" was filed with the Court (*R.A.J. v. Miller, Supplemental Agreement,* 1983). This policy since has become a TDMHMR rule on psychotropic medications. The policy defines dosage ranges for each major class of psychotropic medication, has specific ranges for adults, children, and geriatric clients, and contains guidelines on how medication usage monitoring should be conducted by the hospitals.

*April 1983 through April 1984.* Report to the court. Findings of noncompliance. A policy on consent to adminstration of psychotropic medications.

The charter which defined the roles and responsibilities of the review panel required that the panel present formal reports to the court every six months concerning defendants' compliance with the issues in the settlement agreement. The first two reports expressed concerns in the area of the provision of individualized treatment planning and programming for patients. The panel also was concerned about the TDMHMR's ability to place mentally retarded clients who had been determined to no longer need psychiatric hospitalization within the required 45-day period.

In December 1983 the panel submitted its Third Report to the Court concluding that there were four areas of noncompliance with requirements of the settlement agreement (*R.A.J. v. Miller, Review Panel Third Report,* 1983). These included the following:

- ☐ Lack of individualized treatment planning and programming.
- ☐ The high degree of aggressive or violent behavior in the hospitals.
- ☐ Inadequate staffing to deal with either program needs or with aggressive behavior.
- ☐ The fact that mentally retarded patients who had been identified as no longer needing inpatient psychiatric hospitalization were not being discharged or placed in appropriate facilities within the required time frame.

Based on the review panel's findings in this report, the court ordered an evidentiary hearing to be held in February 1984. Up to this point the parties

seemingly had agreed that the settlement agreement represented issues that all of the parties wanted to accomplish. In the evidentiary hearing, however, it appeared that defendants had major disagreements with the requirements of the settlement agreement and certainly with the findings of the panel. Defendants vigorously disagreed with the panel's conclusion that there was inadequate staffing, that there was an unacceptable level of violent or aggressive behavior in the facilities, or that nonmedical psychosocial programming was not taking place in a relevant manner.

In April 1984 Judge Barefoot Sanders found that the TDMHMR was out of compliance in the three areas of lack of individualized treatment, inadequate staffing, and the high degree of aggressive behavior in the hospitals (*R.A.J. v. Miller, Memorandum Opinion,* 1984). The judge did not find the department out of compliance in the area of placing clients with mental retardation. The panel believes that this was because the department had just established procedures aimed at expediting the placement of the clients with mental retardation who did not need continued hospitalization and that the court probably was giving the department a period of time to achieve results through the implementation of these procedures.

At the same time that the parties and the review panel were involved in the 1984 evidentiary hearing and subsequent activities, they were negotiating a policy which would define how patients would have the right to consent to psychotropic medications. The settlement agreement required that defendants develop a policy regarding the manner of seeking patients' consent to the administration of psychotropic medications which would include the principles established in two major court cases (*Rennie v. Klein,* 1983, and *Rogers v. Okin,* 1983). In January 1984 the review panel filed a recommendation which presented a rule on consent for the administration of psychotropic medications. Both defendants and plaintiffs objected to this proposed rule. At issue here was disagreement over the question whether patients who were committed involuntarily to a state hospital had the right to refuse psychotropic medications. Plaintiffs maintained that, except for a case of an emergency, which could be adequately defined, the patient did have such an absolute right. Defendants maintained that the fact of an involuntary commitment to a hospital based on being dangerous to self or others indicated that the patient did not have the judgment to exercise such a right. Defendants further argued that psychotropic medications were the primary means of treatment at the state hospital and that it was improper to place a treatment facility into a position where it was unable to perform its primary function. Further negotiations between the parties and the panel did not result in an agreed-on policy but rather in the submission of two policies. One supporting the absolute right of patients to refuse medications was supported by the panel and plaintiffs.

The second, a policy produced by defendants and the United States Department of Justice, supported a client's right to request a second medical opinion and to receive such an opinion concerning the acceptability of the originally prescribed medication.

In a *Memorandum Opinion and Order* filed June 22, 1984, Judge Sanders ruled that defendants' proposed rule adequately protected the rights of involuntary committed patients in light of standards specified in current case law (*R.A.J. v. Miller, Memorandum Opinion*, 1984).

The fact that patients were afforded a two-tier medical review process insured that professional judgment would be exercised. The right to have a treatment review by independent consultant psychiatrists added an additional layer of due process protection for the competent involuntarily committed patient. The court did not find a basis in the applicable case law for an absolute right on the part of a competent involuntarily committed patient to refuse administration of psychotropic medication.

The approval of the defendants' proposed rule established the following procedures for the protection of patients:

- ☐ All patients should be educated about the purpose of their medications, the proposed side effects, and the nature of alternative methods of treatment.
- ☐ Voluntary clients either may consent or refuse treatment with psychoactive medications.
- ☐ An involuntary client may consent to treatment with psychoactive medication or may object to psychoactive medication, and in objecting, effectively request a second opinion of the medication. This second opinion can be provided by a state hospital doctor who is not on the ward where the patient resides or by an outside consultant provided by the hospital. The function of the consultant is to render a medical judgment about the appropriateness of the prescribed psychoactive medication. The consultant is not to render an opinion about whether the client is competent to consent to medication.

*July 1984 through June 1985*. Corrective actions. The $35.50 Program. Hearing on the adequacy of community care.

After the court's finding of noncompliance the parties and the panel negotiated the following corrective actions aimed at addressing the issues of noncompliance.

1. *Individualized Treatment:*
   - ☐ Definitions, standards, and performance measures for individualized treatment would be developed.
   - ☐ There would be continued monitoring of the individualized treatment of patients in the facilities.

2. *Protection from Harm:*
   - ☐ Programs dealing with aggressive behavior would be developed and implemented in each unit.
   - ☐ A quarterly reporting system would be established which would monitor the incidence of aggressive/assaultive behavior.
   - ☐ Standards for evaluating levels and severity of aggressive behavior and injuries as well as methods of reducing the incidence of these behaviors in the facilities would be developed.
3. *Staffing:*
   - ☐ At least two MHMR series personnel would be on each ward during each shift.
   - ☐ A monitoring system would be established which would monitor the patient/staff ratios on a monthly basis.
   - ☐ Staffing ratios would be achieved and maintained by August 31, 1985.

Defendants asked the court to accept the concept that compliance with the staffing ratios could be met through either the hiring of additional staff in the hospitals or through the reduction of the patient populations in each hospital. Judge Sanders accepted this concept under the requirement that patients discharged from the facilities to the community would be discharged to appropriately staffed services. Funds for the staffing requirements were sought and obtained through a special session of the legislature.

Implementation of the action plans in the three noncompliance areas was pursued immediately. A task force met to define the elements of individualized treatment. A second task force was organized to discuss problems of aggression in the facilities and a monitoring system was devised to record the incidence of aggressive behavior. Compliance with the staffing ratio requirements was monitored by the review panel in a series of special reports to the court.

An unanticipated side effect of the implementation of the staffing requirements was the development of a mechanism of putting money into the community which has been called the $35.50 Program. When TDMHMR requested the alternative of complying with the staff requirements through the reduction of the population in the hospitals the commissioner conceived of a means of transferring the monies which would have been used for the hiring of staff to community programs. The specific bed day populations for each mental health authority (MHA) were calculated for a particular baseline period of time. The MHAs then were notified that for every day that they reduced below the baseline utilization rate they could earn $35.50 per day. The earnings would be calculated on a quarterly basis and the payments of funds, therefore, were based on the bed day reductions of the previous quarter.

The $35.50 Program created an incentive for the mental health authorities to focus on serving the chronically mentally ill in the community. The emphasis on a reduction of hospital bed days and the need to maintain a reduction once funds had been earned and services had been financed were direct results of this program. The $35.50 Program provided approximately $38 million of new money into the community mental health system from the summer of 1984 to the summer of 1988.

The decision to attempt to meet the staffing ratio requirements through the reduction of the populations of the hospitals during the late months of 1984 caused a high degree of public concern that TDMHMR was inappropriately dumping clients from the state hospitals to inadequate community resources. This public concern was caused by adverse publicity about one hospital's attempt to reduce the length of stay of patients in acute programs through the aggressive use of psychotropic medications and through the negative publicity generated by patients' being placed on buses from Austin to Houston with a placement overnight at a local shelter.

An evidentiary hearing to examine the appropriateness of defendants' efforts at reducing the populations of the hospitals was held in March 1985. In June 1985 the court ruled that there was no evidence of inappropriate discharging of patients on the part of the hospitals (*R.A.J. v. Miller, Findings of Fact*, 1985). However, the court concluded that many clients discharged from the hospitals were receiving services which were "minimally adequate," and the court found that minimally adequate services did not comply with the court order that community alternatives must be "adequately staffed facilities sufficient to provide appropriate treatment."

*July 1985 through June 1987.* Implementation issues. Panel's findings of noncompliance. Further agreements aimed at bringing compliance.

Defendants criticized the court-ordered staffing ratios on the basis that the ratios were arbitrary and rigid in that they did not permit differential staffing based on the needs of clients. Amendments to the original staffing requirements were worked out through negotiations which permitted the ratios to be met on a hospitalwide basis with the inclusion of therapy technicians and licensed vocational nurses (LVNs) in the ratios. Defendants' rationale for this was that therapy technicians and nonsupervisory LVNs did direct patient care and therapy on the units. These amendments were aimed at permitting the flexibility to move staff around on either a short- or long-term basis to provide increased staffing for any unit that needed it.

A report submitted by the panel on staffing indicated that a number of problems existed in the way implementation was taking place. (*R.A.J. v. Miller, Review Panel Special Report*, 1986). Staffing was so tight at some

hospitals that there was a continued need for the pulling of staff from one unit to another to provide coverage. The need for equalized staffing seven days a week had caused problems of scheduling staff which interfered with patient care and programming. The use of therapy technicians and LVNs in the direct care ratios appeared to interfere with these staffs' job functions. The panel's report and recommendations prompted a long period of negotiation on how to resolve the problems. At times it appeared as if resolution would not be possible and that there would be a need for a court hearing on the staffing issues and a resulting judgment by the court.

In October 1986 defendants presented to the parties and the panel a new proposal which consisted of a change in the direct care staffing ratio and a change in the personnel who would be counted in it. The proposal called for new hospital ratios of 1:4, 1:4, 1:8 on all *R.A.J.* units under the 1:5, 1:5, 1:10 staffing ratios and would include registered nurses (RNs), LVNs, and mental health workers (MHWs) assigned only to one particular unit with no supervisory duties. The benefits of this proposal were that the breadth of expertise of the direct care staffing ratio pool would be increased by the inclusion of RNs and LVNs. The shift to the 1:4, 1:4, 1:8 ratios enlarged the size of the direct care pool but not the actual number of staff present. Therapy technicians would be returning to their previous assignments and schedules resulting in better weekend programming, less loss of time, and more appropriate program emphasis.

Each hospital identified deficiencies in the area of compliance with Life Safety Code standards, JCAH standards for a therapeutic environment, and standards which define accessibility requirements for physically disabled persons. The deficiencies and resulting action plans were developed in 1982 and 1983 and approximately $9 million was available from 1982–1983 and 1983–1984 appropriations. Contracts therefore were developed. The original Life Safety Code expert who had reviewed the hospitals in 1980 was used by the panel for ongoing reviews of progress in this area. In the 1980 reviews the largest deficits were identified at the Terrell, Rusk, Kerrville, and Austin state hospitals. The focus therefore was placed most on monitoring the progress in those facilities. Although there were delays in contracts at several of the facilities, by the summer of 1987 the consultant concluded that substantial compliance in the areas of Life Safety Code renovation was achievable at the conclusion of the work that was currently in progress. Six hospitals had completed all their work in an acceptable manner. Two hospitals had additional construction in progress, but on completion the Life Safety Code renovations would be acceptable.

In a response to the court hearing on the adequacy of aftercare services the panel and parties negotiated criteria to evaluate the community-based services available to patients discharged from the hospitals. It was

determined that these patients should receive an aftercare plan and the services designated in that plan, a follow-up appointment and outreach from the mental health authority (MHA). In addition, the MHAs should attempt to provide case management services and food, clothing, shelter, or other nonclinical support services to those patients who are eligible and need those services.

At the same time these criteria were being developed there was an effort on the part of defendants to define a type of long-term care facility for chronically mentally ill patients which might be housed on state hospital grounds or in the community. The concept was that these facilities would be less labor intensive and therefore would be more economical than a hospital.

The panel raised questions about types of programs, staff levels, program standards, and the types of patients served. These questions were not readily answered, and the idea of developing such a program in cooperation with the panel was discontinued. However, the concept of developing such programs has been pursued by several community centers.

In the fall of 1986 defendants maintained that there would be substantial compliance with all requirements of the lawsuit by April 1987. The review panel therefore conducted monitoring evaluations on each of the issues. The subsequent report, the Tenth Report to the Court, (*R.A.J. v. Miller, Review Panel Tenth Report*, 1987), concluded that there was important progress in the court case in the following areas:

- ☐ The proper use of psychotropic medications. Medications were being used according to well-defined guidelines and monitoring was taking place.
- ☐ Adequate staffing. A reasonable compromise on the direct care staff ratios had been agreed on by the panel and parties and further monitoring of compliance was going on.
- ☐ Protection of patients from harm. There had been a marked decrease in the number of injuries caused by aggressive incidents during a year's time period.
- ☐ Renovation of buildings to comply with Life Safety Code and JCAH Environmental and Accessibility Standards for the Physically Handicapped.
- ☐ There were fewer patients in the hospitals, which increased the availability of treatment resources for these patients.

However, the panel report further concluded that there was lack of compliance in the following areas:

- ☐ Individualized treatment and the provision of psychosocial programming. This included lack of leadership on the part of psychiatrists in the treatment planning process.

- ☐ Lack of standards for the placement of patients into community residential programs.
- ☐ The placement of clients with mental retardation into community services.
- ☐ Maintenance of the staffing ratios in the facilities.
- ☐ The adequacy of community care.

In response to the Tenth Report to the Court the plantiffs' attorneys filed a motion to find the Texas Department of Mental Health and Mental Retardation in contempt of court. Defendants filed objections expressing intense disagreement with the findings and recommendations. It appeared during the summer of 1987 that there would not be any agreement over the issues discussed in the report but that there would have to be an evidentiary hearing to determine the validity of the conclusions of noncompliance. However, in August 1987 defendants initiated negotiations on the recommendations and a Stipulated Recommendation for Compliance was filed with the court in September. This stipulation had been developed through arduous negotiation, and the stipulation responded appropriately to all the concerns expressed in the report. The Stipulated Recommendations for Compliance (*R.A.J. v. Miller, Stipulated Recommendations*, 1987) specifically required the following:

- ☐ The department would make an effort to hire competent, qualified, board-certified psychiatrists or physicians who completed a residency training in psychiatry.
- ☐ Training would be implemented which addressed the clinical treatment issues identified in the Tenth Report which specifically would focus on the development of psychosocial psychiatric rehabilitation.
- ☐ Additional clinical care monitoring would take place.
- ☐ A final mechanism would be adapted to facilitate the placement of clients with mental retardation.
- ☐ The staffing standards for the multiple-disability units (MDUs) would be implemented.
- ☐ A further review would be conducted concerning the types of standards which are needed for residential programs and an evaluation would be conducted on the adequacy of aftercare provided to patients who are placed in residential programs.

These stipulations currently are being implemented. It has been the panel's belief that successful implementation of these requirements could resolve the remaining issues of the court case and could improve greatly the quality of care of patients in the state hospitals and discharged patients from the hospitals who are receiving care in the community.

## Funding

Texas ranks 7th in the nation in terms of total state mental health agency expenditures. However, these expenditures must be compared with the population of the state. In terms of per capita expenditures the state hospitals rank 43rd and the community-based programs rank 48th. The overall rank of per capita mental health expenditures is 48 out of 53 programs. This ranking is based on 1985 expenditure data (Lutterman, Glover, & Mazode, 1987).

The chart following presents the total mental health appropriation by fiscal year for 1983 through 1989 and the amount of new monies appropriated by the Texas legislature during the lawsuit implementation period which can be identified as tied to requirements of the lawsuit. In 1983 the mental health appropriation was $157,233,118. In 1989 the appropriation was $318,189,649, which is an increase of $160.9 million dollars. Of that new mental health money $150.4 million can be identified as appropriated to meet requirements of the settlement agreement and subsequent court orders. However, the appropriations have been a small percentage of defendants' estimation of need. The review panel has considered the mental health system to be grossly underfunded particularly in the area of community-based mental health services.

## Discussion

The scope of the *R.A.J.* settlement agreement was so extensive that it covered the major issues of patient care in the public mental health system. Standards which have been defined through the agreement and subsequent court orders include the protection of patient rights, the proper use of psychotropic medications, and the elements of nonmedical psychiatric treatment, staffing requirements for both hospital and community-based services, and the aftercare service requirements for patients discharged from the hospitals to community mental health programs. The development and subsequent implementation of these standards have not been easy, and the implementation of one requirement often has placed pressure on another segment of the mental health system. The implementation of the rules concerning the use of psychotropic medications in the hospitals has caused a gradual acceptance of these rules in the community programs. Other actions, however, sometimes have caused unanticipated negative side effects.

Defendants have complained that the panel or plaintiffs' attorneys keep raising new issues in the case. There is the suggestion that the suit, therefore, never will be resolved. The panel believes that the suit will be

resolved when patient care improves in the hospitals and is being provided at an adequate level in community-based programs. The panel maintains that the problem of new issues is caused by the fact that the panel interprets compliance as the improvement of patient care. If the achievement of a requirement such as the meeting of a patient/staff ratio does not result in the improvement of treatment, the panel has maintained its position that there is a problem and has looked for additional ways of addressing that problem.

## Mental Health Appropriations 1983–1989

| Total Mental Health Appropriations by Fiscal Year | | New *R.A.J.* Specific Funds by Biennium | |
|---|---|---|---|
| 1983 | $157,233,118 | 1984–85 | |
| 1984 | $181,053,162 | $ 4.0 million | Life Safety Code |
| 1985 | $252,308,885 | 4.6 million | Staffing |
| 1986 | $278,926,190 | 1.7 million | Community-based residential services |
| 1987 | $278,930,558 | $ 10.3 million | |
| 1988 | $308,774,319 | (16% increase in federal mental health block grant) | |
| 1989 | $318,189,649 | 1984 Special Session | |
| | | $ 10.4 million | '84 staffing ratios |
| | | 16.6 million | '85 staffing ratios |
| | | $ 27.0 million | |
| | | 1986–87 | |
| | | $ 40.1 million | Staffing ratios |
| | | 2.6 million | Federal block grant |
| | | 0.3 million | Clients' rights and quality assurance |
| | | $ 43.0 million | |
| | | 1988–89 | |
| | | $ 40.0 million | Contracted community services |
| | | 20.1 million | Staffing ratios |
| | | 10.0 million | Life Safety Code renovations |
| | | $ 70.1 million | |
| | | $150.4 million | |

Implementation and subsequent compliance with requirements of the settlement agreement have been slow to be achieved. Progress has been the most significant in the areas of the proper use of psychotropic medications and the renovations of hospital buildings to comply with fire and safety standards. There are fewer patients in the hospitals, which has increased the availability of treatment resources for these patients. However, the review panel has considered that there were still serious problems with compliance in the areas of individualized treatment and the provision of nonmedical psychosocial programming in the hospitals and in the adequacy of community-based care. The lack of adequate funding for the entire mental health system has created situations where pressure to comply with the lawsuit requirements has drained resources from other parts of the system.

There have been sharp disagreements between the review panel and defendants concerning questions of compliance. This predominately has been in the areas of what constitutes adequate nonmedical psychosocial treatment and what is adequate community-based aftercare for patients discharged from the hospitals.

At this point there are plans in place which, if implemented properly, should lead to improvement of patient care and to resolution of the requirements of the lawsuit. The intent of the settlement agreement has been improved patient care, and the final measures of compliance with the requirements of the lawsuit will be documented improvements of patient care in the hospitals and the provision of adequately staffed services in the community.

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# Children's and Adolescents' Mental Health Needs in Texas: A Time for a Vision

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Children and adolescents comprise at least one-third of the general population in Texas. They are also a population that traditionally has been neglected or underserved by the state's social service system. The inadequacy of mental health services for children has been an issue of long concern in our society. As early as 1909 a White House conference on children identified the need for new programs to care for mentally disturbed children.

Some twenty years later, in 1930, a second White House conference expanded the previous recommendation to include the concept of normalization in stating that mentally disturbed children had the right to develop in the same manner as their nonhandicapped peers.

The first comprehensive assessment of the magnitude of children's mental health problems was presented by the Joint Commission on the Mental Health of Children (1969). The commission was established in 1965 under Public Law 89–97 to produce a report which focused on the diagnosis, prevention, and treatment of mental illness in children and adolescents.

The commission reported that emotionally disturbed children did not receive appropriate services. The most disturbed children and adolescents were being treated in state hospitals and other facilities which merely provided custodial care rather than active treatment. There was also a lack of coordination of existing services. The following principal recommendations were made:

- ☐ Child advocacy system be established at a federal, state, and local level to facilitate the development of children's mental health services.
- ☐ Community services be established that focus on prevention and remediation of mental illness.
- ☐ Severely disturbed children be provided treatment services in settings that resemble normal living situations.

One of the major obstacles faced by the Joint Commission in its study of child mental health was the lack of specific diagnostic criteria on the definition of emotional disturbance. A study by the United States Department of Health, Education, and Welfare (Hobbs 1975) attempted to

address this problem. This study was concerned with the identification and service needs of children who were socially, physically, and emotionally handicapped. The results of the project emphasized the importance of classifying disorders without inappropriately labeling children, the need for coordination of services across agencies and categories of children, and the right of all children with handicapping conditions to have access to public education. This final recommendation was implemented successfully in the passage of Public Law 94-142, the Education for All Handicapped Children Act.

The classification project also made specific recommendations on program and policy development in the following areas:

- ☐ Support for parents
- ☐ Improved residential programs for children
- ☐ Improved organization of services

As in the Joint Commission report, the role and importance of advocacy was seen as instrumental to the development services.

Another presidential commission was developed to examine the crisis in mental health care in the country. The Task Panel on Infants, Children and Adolescents (1978) found that there had been no implementation of the 1969 Joint Commission report. Children and adolescents continued to receive inadequate and inappropriate services. There were also an insufficient number of professionals with training on the special needs of children and adolescents to provide the care.

The Task Panel report (1978) went on to recommend preventive services to all children, not only those who were identified as emotionally disturbed. It was suggested that there be an incorporation of diagnostic mental health services and developmental assessments into the ongoing health care of all children. The 1978 Task Panel also made the following recommendations:

- ☐ Services provided should include parents and significant others and be sensitive to developmental needs and ethnic differences.
- ☐ Services provided should prevent disruption of the family. Health insurance plans must eliminate barriers to reimbursement of outpatient treatment.
- ☐ Mental health services must be organized along a continuum of care which includes diagnostic, outpatient, and residential services.
- ☐ Improved research and evaluation studies on appropriate treatment should be developed. To cut these programs in favor of treatment services was viewed as a potential waste of resources.
- ☐ Mental health services for adolescents which address suicide, pregnancy, and delinquency should be developed, and such services must be integrated in schools, juvenile courts, and other community programs.

In 1981 another select panel was established with interest in mental health. The Select Panel for the Promotion of Child Health was developed as part of Public Law 95-626. The panel focus was on the analysis of federal programs affecting children. The implementation of services enacted through Public Law 94-142 as well as those identified in the Mental Health System Act of 1980 was addressed.

The panel noted that the passage of Public Law 94-142 had resulted in significant changes in attitudes toward children with handicapping conditions, but that there were still very limited services available. The panel (Select Panel for the Promotion of Child Health, 1981) also identified the need for:

- ☐ Federal and state monitoring, technical assistance, and enforcement to ensure identification and evaluation of children with handicapping conditions as well as mental health services provided to them.
- ☐ Services through community mental health centers and other mental health delivery systems that include services to children. (These services previously were provided through Part F funding, which was repealed in 1975.)
- ☐ Mental health services that include assessment and prevention as well as outpatient and residential treatment.
- ☐ Coordination of services of welfare, school, juvenile justice, and other child-serving agencies.

Despite the recommendations of numerous panels and commissions, little change occurred within the coordination or delivery of mental health services to children and adolecents. In 1982 a critically acclaimed study was undertaken by the Children's Defense Fund on the mental health treatment of children and adolescents who were mentally ill. Knitzer (1982) further illuminated the destitute plight of this population. The survey described services to children and adolescents in the United States and the District of Columbia. This comprehensive assessment generated original data on the needs of the identified population.

Knitzer (1982) reported that only one-third of the estimated three million seriously emotionally disturbed children were receiving needed or appropriate services. Poor and minority children were most often found to receive no services. Knitzer's work also revealed that inpatient services, which are the most costly and restrictive, were also the most accessible. A need for both long- and short-term residential placements was identified in one-third of the states. A correlation also was found between the dependence on medical model inpatient programs which received a disproportionate amount of federal funds and the lack of federal funding to a limited number of less restrictive community-based programs. This report, like the others that preceded it, stressed the need for increasing efforts in identifying the children and youth in need of services, develop-

ment of a continuum of community-based services, coordination of service across agencies, and target and incentive funding to enhance the service delivery system. Table 1 provides an overview of selected findings and recommendations of the previously mentioned reports (U.S. Congress, Office of Technology Assessment, 1986, p. 20).

Lack of funding has been a major hindrance to the development of mental health services. As previously mentioned, one of the specific recommendations of the Knitzer report was the targeting of federal dollars for children's mental health services. The proportion of funding through such programs as the Alcohol, Drug Abuse, and Mental Health (ADM) block grants, Medicare, Medicaid, and the CHAMPUS program is difficult to determine. Even though the 1988 block grant required a 10 percent set-aside for children's services, the entire set-aside may be no more than $20 million. Only a small percentage of the identified $20 million will be directed toward new programs. Lack of new funds for set-aside requirements forced participating states to take money from existing programs. Another problem was created with the stipulation that programs for underserved populations, including children, only could utilize block grant funds if they were new projects. Funding could not be used to expand existing efforts.

These issues necessitated that Congress amend the 10 percent set-aside requirement in fiscal year 1986. Public Law 99-1171 placed stronger emphasis on the utilization of funds for children and adolescents through new or expanded programs. It is important to note that these funds provide an incentive for the development of community-based services because inpatient services are excluded.

Medicare covers some, but very few, mentally disabled children. While the actual amount of medical services provided to children is not easily documented, it can cover a wide range of mental health services. Through Supplemental Security Income (SSI), Medicaid is a significant payer of institutional care. Mandatory Medicaid services include: inpatient hospitalization, outpatient hospitalization, including day treatment and partial hospitalization, physicians, and Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program services.

The EPSDT program provides assessment and evaluation services to young children. However, according to Fox (1987), the inherent flexibility of the benefit is not being utilized as well as it could be for all children, and particularly for mentally ill children. Only 19 states (Alaska, Arkansas, Connecticut, Delaware, Florida, Hawaii, Illinois, Kansas, Kentucky, Maryland, New Jersey, New York, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, and Wisconsin) and the District of Columbia provide expanded coverage under EPSDT. While all states are in

compliance with the federal mandate to require a developmental assessment as part of EPSDT screening examinations, only seven states (Alabama, Delaware, Louisiana, Michigan, South Dakota, Utah, and Vermont) require any specific screening for psychiatric and psychological problems. The choice of the developmental assessment tool is left to the states.

The Medicaid 2176 home and community-based waiver program, under which states may greatly expand home care to individuals in lieu of institutionalization, has been utilized very effectvely for mentally retarded children, but remains greatly underutilized for children with other mental and physical illnesses. There are widespread reports of state reluctance to request waivers because of the very burdensome administration requirements. Currently only one state, Vermont, administers a program providing home and community-based services to mentally ill children.

Optional medical services include prescription drugs, case management, clinic services (including community mental health services), inpatient psychiatric facilities, and intermediate care facilities for the mentally retarded. As noted in the example of EPSDT services, each state develops its own Medicaid plan and identifies the types of mental health services it will pay for. At present, the Texas plan does not include day treatment, case management, and many other therapeutic services.

Another key component to the federal health care financing system is CHAMPUS. This program provides medical coverage, including mental health care, to military dependents and retirees. For children, these services include outpatient, inpatient, and residential treatment services.

In recent years, there has been an increase in use of inpatient and residential treatment services through CHAMPUS. In an attempt to change the reimbursement policy, a 60-day cap was placed on inpatient hospitalization.

The 60-day cap requires that there be justification for extending hospitalization. This limit will in turn encourage treatment with less restrictive facilities and community programs. At present there is no cap on the use of residential treatment programs.

The reduction of outpatient mental health resources and decreasing institutionalization have resulted in an increased reliance on special education as a mental health service provider for emotionally disturbed children (the Education to All Handicapped Act, Public Law 94-142). The federal government provides limited funds for "related services," which can include counseling, parent training, expressive therapy, and residential treatment for educational purposes. In most states, however, use of related services has been very unevenly distributed to the population of children in need.

**Table 1**
**Mental Health Services for Children: Selected Findings and Recommendations of Past National Study Panels**

| Selected conclusions | Selected recommendations | Subsequent federal actions |
|---|---|---|
| *White House Conference on Children (1909):* | Develop new programs to care for emotionally disturbed children. | |
| *White House Conference on Children (1930):* | | |
| Emotionally disturbed children have the "right" to develop like other children. | Develop new programs to care for emotionally disturbed children. | |
| *Joint Commission on Mental Health of Children (1969):* | | |
| Large numbers of emotionally, physically, and socially handicapped children do not receive necessary or appropriate services. | Establish a child advocacy system to coordinate federal, state, and local action.<br>Establish community services focused on prevention and remediation.<br>Expand prevention services to include family planning, prenatal care, nutrition, and other physical health care.<br>Deliver treatment in settings resembling normal living conditions.<br>Increase research on diagnosis and treatment. | |
| *Project on the Classification of Exceptional Children (1975):* | | |
| Services for all kinds of children remain a tangled thicket of conceptual confusions, competing authorities, contrary purposes, and professional rivalries, leading to the fragmentaion of services and the lack of sustained attention to the needs of individual children and their families. | Classify disorders, not children.<br>Coordinate and plan services.<br>Educate all children; make public schools advocates for all services for all children. | Education for All Handicapped Children Act (Public Law 94-142) passed in 1975. |
| *President's Commission on Mental Health or Its Task Panel on Infants, Children, and Adolescents (1978):* | | |
| A delay in the delivery of mental health services is no more justifiable than a delay in the delivery of physical health services.<br>Adolescents are one of the most underserved groups in nation.<br>Mental health commissions have to date garnered little action for minority group programs. | Provide prevention services (e.g., prenatal care) to all families with children.<br>Services should "respect ethnic differences," be adapted to children's specific needs, treat significant others.<br>Incorporate mental health services (e.g., developmental assessments, diagnostic services) into general health care.<br>Involve parents in development of treatment, educational, and service plans.<br>Develop a network of psychiatric, pediatric, counseling, special education, and occupational training services. | Mental Health Systems Act (1980) authorized programs to improve the delivery and coordination of services for severely emotionally disturbed children and adolescents (repealed in 1981). |

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| | | |
|---|---|---|
| | Organize mental health services along a continuum of intensiveness.<br>Increase residential and outpatient care.<br>Make mental health care available at reasonable costs to all who need it.<br>Address adolescent suicide, teenage pregnancy, delinquency, and substance abuse.<br>Increase the number of mental health professionals trained to work with children.<br>Fund more basic and evaluation research. | |
| *Select Panel for the Promotion of Child Health (1981):*<br>Public Law 94-142 (the Education for All Handicapped Children Act) has wrought significant improvements, but substantial variations exist in the availability of services. | Develop better means of identifying and evaluating children with handicapping conditions, including serious emotional disturbance.<br>Require delivery of health and mental health services to handicapped children.<br>Improve federal and state monitoring, technical assistance, and enforcement of Public Law 94-142.<br>Expand mental health services to include early detection and treatment of developmental problems, other preventive services for children and families, high-quality residential treatment services, and community support mechanisms.<br>Develop new means of coordinating physical and mental health services, and mental health services with educational and social services.<br>Involve families in delivery of mental health services. | |
| *Knitzer/Children's Defense Fund Survey of State Mental Health Programs:*<br>All services (residential and nonresidential) are inadequate.<br>Inpatient psychiatric care is the most accessible, but also the most costly and restrictive.<br>States do not monitor children's progression through mental health system.<br>Service systems (juvenile, educational, child welfare, mental health) are uncoordinated.<br>Seriously emotionally disturbed children appear to be underserved under Public Law 94-142. | Increase efforts to identify children and adolescents in need of services or who are inappropriately served.<br>Develop incentives for creating coordinated services.<br>Coordinate juvenile justice, education, child welfare, and mental health services by means of a child advocacy system.<br>Target federal alcohol, drug abuse, and mental health (ADM) block grant funds for children's services. | Child and Adolescent Service System Program (CASSP) was funded to promote coordination of mental health services within states.<br>Ten percent of ADM mental health block grant funds was set aside for children or other underserved populations. |

*Sources:* Joint Commission on the Mental Health of Children (1969), Hobbs (1975), President's Commission on Mental Health (1978, vols. 1 & 3), Select Panel for the Promotion of Child Health (1981), Knitzer (1982).

The newly enacted Public Law 99-457 will ensure comprehensive early intervention services for children from birth to age 3 who are experiencing developmental delays. Like Public Law 94-142, a provision for mental health services is included. It is also important to note that each state has the responsibility of defining the population of children to be served under Public Law 99-457. This population also can include those children who are "at risk" for substantial delay, which could involve prevention services to children at high risk for the development of emotional problems.

The lack of coordinated efforts in the delivery of services to emotionally disturbed children has been cited in numerous national reports. In 1984 Congress provided appropriations for the creation of the Child Adolescent Service System Program (CASSP), which is administered by the National Institute of Mental Health (NIMH). CASSP was modeled after the Community Support Program for the Chronically Mentally Ill. The goal of CASSP is to ensure the availability and delivery of comprehensive services to emotionally disturbed children through a coordinated system of care.

The CASSP effort has been implemented through the funding of State System Development Grants and demonstration projects which focus on interagency service organization. There is also a major thrust toward advocacy efforts and the collaboration of parents and professionals in the planning and delivery of services. The CASSP program has the unprecedented potential for successfully directing and improving federal, state, and local community mental health service delivery systems for emotionally disturbed children and adolescents.

The mental health service delivery system in Texas has been plagued by the same problems identified in the various reports on children's mental treatment. Lack of community-based services, lack of coordination between agencies serving children, and limited funding have been the key issues.

The Texas Department of Mental Health and Mental Retardation (TDMHMR), like other agencies, historically has been unresponsive to the needs of children and adolescents. This problem primarily has been created by a lack of state and federal funding. It is important to note that TDMHMR has opted not to utilize the ADM block grant 10 percent set-aside for underserved populations for children's services. Instead, these funds have been used for the elderly and homeless. Tables 2 and 3 taken from Children's Mental Health Needs and Problems (U.S. Congress 1986), provide information on state utilization of ADM block grant funds for children's services. The Texas Commission on Alcohol and Drug Abuse has allocated ADM funds for substance abuse prevention and inhalant abuse programs for children and adolescents.

Funding for children's community services has become even more limited over the past several years because of the *R.A.J. v. Miller* federal

court settlement which primarily focuses on the delivery of services to the chronically mentally ill adult population. In addition, TDMHMR has not had a centralized and coordinated focus on the child and adolescent population. Until this time, this special population has been assumed under adult mental health definitions and service provisions. Since children and youth comprise such a large portion of the population, distinct treatment programs and policies must be developed in their behalf.

Table 2

Planned Use in Selected States of Fiscal Year 1985
Set-Aside Funds for Mental Health Services for Children

| State[a] | Services for children[b,c] |
|---|---|
| California | Not decided[d] |
| Colorado | Residential care |
| Florida | Psychiatric services, summer school session for the handicapped, outpatient, emergency, diagnostic assessment, consultation, case management, crisis intervention, adolescent problem prevention |
| Iowa | Group home services, adolescent problem prevention, family support |
| Kentucky | None (funds will be used for other underserved areas of populations) |
| Massachusetts | None (funds will be used for other underserved areas of populations) |
| Michigan | None (funds will be used for other underserved areas of populations) |
| Mississippi | Undetermined[e] |
| New York | Family support, adolescent suicide prevention, referral |
| Pennsylvania | Residential care |
| Texas | Services for students with drug or alcohol problems, weapons violations, etc., services for minority inhalant abusers |
| Vermont | Not decided[d] |
| Washington | None (funds will be used for other underserved areas of populations) |

[a] A sample of 13 states, representing the receipt of about half the Alcohol, Drug Abuse, and Mental Health block grant funds, were surveyed by the General Accounting Office.

[b] The listed uses represent plans surveyed as of May 1985.

[c] Block grant set-aside funds also were permitted to be used for underserved populations other than children. In addition some underserved populations that the states reported were to be served (e.g., the homeless chronically mentally ill) were not targeted by age. Some of these programs may address the mental health needs of children.

[d] "Not decided" indicates that the state had not decided whether set-aside funds were to be used for children or for other underserved areas of populations.

[e] "Undetermined" indicates that the state had decided to use set-aside funds for children and adolescents, but had not decided which services the funds were to be used for.

Table 3

Fiscal Year 1985 Estimated Allocation of the 10% Set-Aside of the Alcohol, Drug Abuse, and Mental Health (ADM) Block Grants for Selected States

| State | Total ADM award for fiscal year 1985 | Mental health portion of total ADM award amount/percent | Total planned set-aside funds as of May 1985 | *Set-aside funds allocated* Children | Underserved areas or populations |
|---|---|---|---|---|---|
| California | $ 48,406 | $15,778 (33%) | $ 2,328 | $ 0 | $ 0 |
| Colorado | 7,004 | 3,400 (49%) | 340 | 144 | 196 |
| Florida | 24,033 | 12,855 (53%) | 1,358 | 377 | 1,021 |
| Iowa | 2,936 | 203 (7%) | 20 | 20 | 0 |
| Kentucky | 4,551 | 1,850 (41%) | 669 | 0 | 669 |
| Massachusetts | 18,240 | 10,106 (55%) | 1,011 | 0 | 1,011 |
| Michigan | 15,948 | 4,708 (30%) | 471 | 0 | 471 |
| Mississippi | 5,165 | 3,606 (70%) | 361 | 361 | 0 |
| New York | 40,097 | 9,700 (24%) | 1,153 | 203 | 950 |
| Pennsylvania | 25,114 | 13,250 (53%) | 1,326 | 230 | 1,096 |
| Texas | 21,446 | 8,457 (39%) | 846 | 846 | 0 |
| Vermont | 3,313 | 2,200 (66%) | 220 | 0 | 0 |
| Washington | 8,977 | 4,727 (53%) | 526 | 0 | 0 |
| Total (13 states) | $225,230 | $90,840 | $10,629 | $2,141 | $5,940 |

*Note:* The information represented in the table was surveyed as of May 1985. Set-aside funds are to be used for new programs only; therefore, amounts in this table do not represent states' entire expenditures on either children or underserved areas of population. Some states set aside more than the required 10% of the mental health portion of block grant funds.

## Table 4

## State Facilities Serving Children and Adolescents in Texas

| Psychiatric child and adolescent units | Bed capacity C & A | FY 1986 ADC | FY 1986 daily cost | FY 1987 C&A residential funds (8400 acct.) | FY 1987 community contract funds | Admission policy | Waiting list |
|---|---|---|---|---|---|---|---|
| Austin | 25 A<br>40C | 65 | $168.67 | $800,000 A<br>$1,000,000 C | (unknown) | Court commitments<br>Few voluntary<br>when screened | Yes |
| Big Spring | 22 A | 20 | $129.36 | $564,000 | (a few children placed in private treatment facilities) | Court commitments mostly | Occasionally set up extra bed |
| Kerrville | None | None | NA | NA | Funds for two patients contract at daily rate $140.00 with Children's Hospital, San Antonio | Refer to San Antonio Adolescent Unit | NA |
| Rusk | None | None | NA | NA | Contract with Beaumont $800,000 for 40 C & A beds | Voluntary primarily after screening | NA |
| San Antonio | 29 A | 23 | $155.10 | $650,000 | $549,000 for service days with Children's Hospital | Court commitments primarily | No |
| Terrell | 15 C<br>60A | 52 | $152.46 | $1,706,620 | (unknown) | Court commitments and screened voluntary | Seasonal |
| Witchita Falls | 21 C<br>30 A | 37 | $128.58 | $800,000 | (unknown) | Court commitments and screened voluntary (also Vernon referrals) | Seasonal |
| Waco | 90 C & A<br>(100 FY '87) | 84 | $129.74 | $2,594,581 | $100,000 for aftercare | Mostly parental signed consent on voluntary | 40–60 monthly |
| Totals | 342 | 281 | — | $8,115,201 | — | — | — |
| Vernon (drug abuse) | 159<br>(130 FY '87) | 125 | $103.88 | $2,860,000 | None | Mostly condition of probation | Two-month MHA screening period |

The delivery of mental health services to children and adolescents has been limited to traditional models with the majority of these services being provided through the state hospital system. There are five regional hospitals providing specialized inpatient care to the target population and one community-based facility. Two additional facilities, Waco Center for Youth and Vernon Substance Abuse Unit, provide residential treatment to children and adolescents from around the state. Table 4 provides a list of state facilities serving children and adolescents.

The state hospital programs are designed to serve patients who are in need of acute psychiatric care. However, many children also are forced to remain in the hospitals past the acute treatment phase due to limited funding for residential placements and lack of community-based services. In Texas the number of residential beds for emotionally disturbed children is 3.2 per 100,000 population. The national average is 7.2 per 100,000. Many states, such as California, New York, and Pennsylvania, have 9 beds or more per 100,000 population.

There is also a monumental need for community-based services in Texas. The previously mentioned funding inequities have created an inadequate approach to service delivery. Children and adolescents, unlike the adult population, have not been guaranteed the provision of "core services" at the local level due to a paucity of resources and fragmentation of existing service delivery. Core services include crisis stabilization, client and family support, medication-related services, independent living skills, case management, vocational skills development, mental health service, and social support activities.

The limited services provided at the community level vary greatly by region. There is little or no correlation between population size and services provided. According to the 1984 TDMHMR task force report on child and adolescent mental health (Texas Department of Mental Health and Mental Retardation, 1984), 22 percent of the state's youth reside in South Texas (Mental Health Region 4) which has the greatest need for inpatient-outpatient screening, emergency, and residential services. West Texas (Region 1), which comprises 15 percent of the population, was found to have the lowest number of residential beds.

In general, the continuum of community-based services is much more developed in the urban areas. East Texas (Region 5), which encompasses Houston, has the highest percentage of population under the age of 18. Second in rank is North Texas (Region 6), which includes Dallas. The Dallas and Houston community mental health centers are two of the nine centers in the state which have separate and identifiable child and adolescent service units within their organization. Both have been very successful in the development of interagency programs as well as obtaining line item community funding for their children's services.

The delivery of mental health services to rural Texas is one of the system's greatest challenges. The capacity to develop services that will meet the needs of such a geographically and culturally diverse group of people is a complex task. Such a delivery system must be flexible enough in design to address the mental health needs of the predominantly Hispanic communities of the Rio Grande Valley as well as those isolated communities throughout the West Texas desert.

Rural communities in Texas are in a state of crisis due to plummeting oil and gas prices, declining land values, and the loss of the institution of family farming. A report on rural mental health in Texas (Barry & Mountain, 1987) has indicated an increase in child abuse, substance abuse, and suicide among the youth population and their families.

Current census estimates indicate that there are 5,026,719 children in the 0–17 age range residing in Texas. Using nationally established prevalence rates, 11.8 percent or 578,072 of the general population can be classified as emotionally disturbed and in need of mental health services. Of these identified children and youth, 251,336 are estimated to be seriously emotionally disturbed. At the present time, there is a great discrepancy between the expected number of children who should receive services from the state system or public sector (100,534) and those who actually utilized those services. During FY 1987 20,000 children and adolescents were served by TDMHMR. Based on current rates, only 20 percent of the children and adolescents in need of nonresidential and residential services received them (TDMHMR, 1988).

Another major obstruction to the child/adolescent mental health delivery system has been the TDMHMR priority service population definitions. The adult definitions focus on the criteria of dangerousness and dependency with little emphasis on the level of social functioning. The present categories also do not reflect the multi-agency needs of many of these children and youth which require an interagency collaboration and coordination of services.

The children and adolescents who receive services through TDMHMR are part of the mental health population who according to specific criteria are most in need of treatment and support. The determination of need is based on a mix of characteristics which render the mentally dysfunctional person currently or potentially dangerous, dependent on external community resources, and therefore at risk of hospitalization. The priority service groups are listed in order of priority use of state funds. These service groups are as follows:

I. Chronically dysfunctional mental disorder with present dangerousness or dependency. In children and adolescents the duration of illness is six months.

II. Historically dysfunctional mental disorder with present dangerousness and/or dependency.

III. Primary commitment: a person with present dangerousness, first time commitment.

IV. Chronically dysfunctional mental disorders with threat of deterioration to dangerousness.

V. Dysfunctional mental disorder with threat of deterioration to dangerousness or dependency.

VI. The final service group, the nonpriority population service group, is defined as "all other persons receiving mental health services." This category includes:

a. Dysfunctional mental disorder without threat of deterioration to dangerousness/dependency.

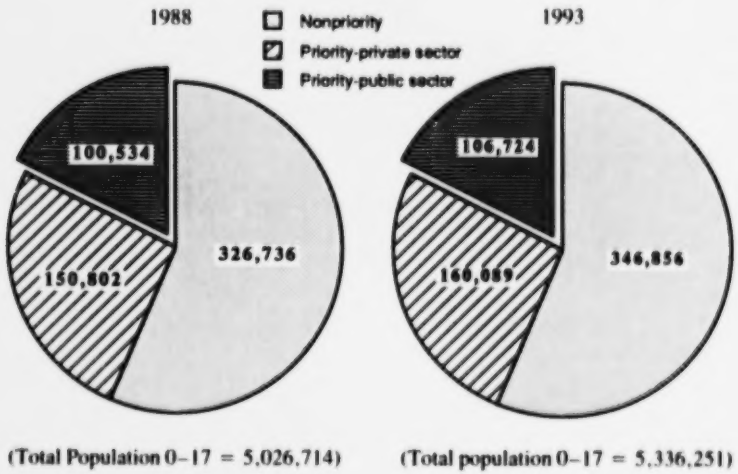
b. At risk of dysfunctional mental disorder. Failure to receive psychiatric service may result in subsequent dysfunctional mental disorder.

c. All persons receiving services, or screened and referred to other community resources.

(See Appendix A for a complete description of the service group criteria.)

Figure 1 provides a graphic illustration of the service prioritization (TDMHMR, 1988).

*Figure 1.* Needs of Children and Adolescents with Mental Health Problems in Texas*




*These data are based on National Institute of Mental Health State Mental Health Planning Guidelines.

Priority service group utilization rates examined between March and May of 1988 indicate that adolescents between the ages of 15 and 17 in service groups I–III were the highest utilizers of state hospital, campus, and community programs as well as community center outpatient services (see Table 5). In general, the community centers provide the majority of services to children of all ages. Differences, however, are found both in age and priority service groups for those who receive treatment. Children age 0–5 in priority group V, age 6–11 in priority group IV, and age 12–14 in priority group IV were the highest utilizers of community center programs.

The community center utilization rates also appear to indicate that children and adolescents in priority group VI are receiving some level of

Table 5

Texas Department of Mental Health and Mental Retardation
Clients by Age and Service Groups, March 1 through May 31, 1988

| Facility | Service group | Age 0–5 | Age 6–11 | Age 12–14 | Age 15–17 |
|---|---|---|---|---|---|
| State hospitals, campus program | MH-I | 0 | 12 | 127 | 287 |
| | MH-II | 0 | 2 | 13 | 15 |
| | MH-III | 0 | 2 | 2 | 24 |
| | MH-IV | 1 | 6 | 12 | 19 |
| | MH-V | 0 | 2 | 3 | 10 |
| | MH-VI | 0 | 2 | 2 | 5 |
| State hospitals, community program | MH-I | 1 | 61 | 42 | 71 |
| | MH-II | 0 | 4 | 8 | 12 |
| | MH-III | 0 | 8 | 1 | 10 |
| | MH-IV | 5 | 32 | 31 | 29 |
| | MH-V | 7 | 37 | 37 | 48 |
| | MH-VI | 4 | 14 | 11 | 9 |
| Community centers | MH-I | 232 | 554 | 577 | 1,104 |
| | MH-II | 101 | 244 | 309 | 744 |
| | MH-III | 71 | 346 | 399 | 796 |
| | MH-IV | 156 | 931 | 806 | 1,195 |
| | MH-V | 591 | 623 | 555 | 582 |
| | MH-VI | 99 | 538 | 393 | 392 |

services even though state funds for those services are limited. Following the notion that "early intervention is the best prevention," it would seem that more emphasis must be placed on providing treatment for those children and adolescents with mental illness who are at acute risk of becoming more disturbed and later requiring more costly and restrictive types of treatment. This issue will be addressed in new service definitions being developed specifically for the child and adolescent population and will be included in the State Plan for Children's Services. See Appendix B.

Data on utilization of services of community centers and state hospitals by minority groups reveal a pattern of underutilization. Of all male clients, white males ages 6–11 had the highest utilization rate. Though fewer in numbers, the majority of black, Hispanic, and Asian male clients were in the 0–5 age group; community center services to this age group are provided primarily through the early childhood intervention (ECI) program, which has an active "child find" component. Of all female clients, white females in the 15–17 age group had the highest utilization rate. The largest population of minority females was in the 0–5 age group, as for males. Table 6 illustrates this point.

Table 6

Children and Adolescents Served in Community Centers by Age, Sex, and Ethnicity, March 1 through May 31, 1988

| | Age 0–5 | Age 6–11 | Age 12–14 | Age 15–17 |
|---|---|---|---|---|
| Male | | | | |
| Black | 993 | 720 | 524 | 743 |
| Hispanic | 1,224 | 677 | 542 | 822 |
| White | 2,068 | 2,251 | 1,647 | 2,229 |
| Asian | 46 | 19 | 12 | 20 |
| Am. Indian | 7 | 4 | 4 | 5 |
| Other | 26 | 16 | 7 | 7 |
| Subtotal | 4,364 | 3,687 | 2,737 | 3,826 |
| Female | | | | |
| Black | 666 | 358 | 288 | 509 |
| Hispanic | 900 | 422 | 356 | 532 |
| White | 1,135 | 1,362 | 1,021 | 1,853 |
| Asian | 34 | 9 | 10 | 11 |
| Am. Indian | 5 | 4 | 6 | 5 |
| Other | 17 | 4 | 5 | 8 |
| Subtotal | 3,057 | 2,159 | 1,686 | 2,918 |
| Total | 7,421 | 5,846 | 4,423 | 6,744 |

From March through May of 1988 both white males and females in the 15–17 age group had the highest utilization rate for hospital services (Table 7). Among black and Hispanic males and females, those in the 15–17 age group were the highest users of state hospital services. However, these numbers are very small in comparison to the population of whites.

The extremely low utilization rates for the black and Hispanic population between 15 and 17 is important to note because the group is overrepresented in the "dropout" category in public education, as well as being overrepresented in the juvenile justice system. Table 7 provides this information.

Table 8 illustrates the number of minority youth served in state hospitals compared with youth committed to the Texas Youth Commission/juvenile justice system in 1988. These statistics may raise several questions in regard to the availability and acceptability of traditional mental health services of the black and Hispanic communities as well as the apparent

Table 7

Children and Adolescents Served in Hospitals (Campus)
by Age, Sex, and Ethnicity, March 1 through May 31, 1988

| | Age 0–5 | Age 6–11 | Age 12–14 | Age 15–17 |
|---|---|---|---|---|
| Male | | | | |
| Black | 0 | 5 | 20 | 28 |
| Hispanic | 0 | 3 | 29 | 64 |
| White | 1 | 45 | 84 | 189 |
| Asian | 0 | 0 | 0 | 1 |
| Am. Indian | 0 | 0 | 2 | 0 |
| Other | 0 | 0 | 1 | 1 |
| Subtotal | 1 | 53 | 136 | 283 |
| Female | | | | |
| Black | 0 | 7 | 12 | 16 |
| Hispanic | 0 | 2 | 17 | 37 |
| White | 0 | 16 | 52 | 114 |
| Asian | 0 | 0 | 0 | 0 |
| Am. Indian | 0 | 0 | 0 | 0 |
| Other | 0 | 1 | 2 | 0 |
| Subtotal | 0 | 26 | 83 | 167 |
| Total | 1 | 79 | 219 | 450 |

tendency for these youth to be viewed as being "bad and mad" and more appropriate for juvenile justice intervention as opposed to being "sad or emotionally disturbed" and in need of mental health intervention.

The underutilization of mental health services by children and adolescents is not only a result of the lack of available services but the underidentification of children with emotional problems as well. Current utilization data also indicate that only small numbers of minority children receive mental health services. For many children it is through their contact with the public education system that they are first recognized as having deviant behavior or emotional problems. This recognition then initiates the process of referral and treatment.

The prevalence rate of emotional disturbance for the school-age population in Texas is 0.66 percent, less than 1 percent. The Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task

Table 8

Adolescents in Juvenile Justice or Mental Health Systems, 1988 Commitments

| | Ages 12–14 | Ages 15–17 |
|---|---|---|
| Texas Youth Commission | | |
| Black | 114 | 417 |
| Hispanic | 244 | 552 |
| White | 121 | 424 |
| Other | 0 | 17 |
| Total | 479 | 1,410 |
| State hospitals, involuntary | | |
| Black | 23 | 52 |
| Hispanic | 50 | 156 |
| White | 108 | 316 |
| Other | 2 | 2 |
| Total | 183 | 526 |
| State hospitals, voluntary | | |
| Black | 29 | 48 |
| Hispanic | 35 | 93 |
| White | 100 | 270 |
| Other | 5 | 2 |
| Total | 169 | 413 |

Force on Emotional Disturbance (1988) also reported that one-third of the school districts in the state identify no students as emotionally disturbed. Another one-third identify fewer than half of 1 percent (0.50 percent). Of the roughly 21,000 students classified as emotionally disturbed and eligible for graduation, 44 percent dropped out of school. These disturbing statistics indicate that the majority of school districts are not in compliance with state and federal requirements that emotionally disturbed children be identified and receive appropriate service. Since services to emotionally disturbed children are dependent on the identification process, they cannot be presumed to exist where identification is lacking.

To solve this dilemma, the Task Force has recommended that 2 percent of the total school population be an acceptable standard for prevalence of emotional disturbance in the school-age children. This is in accordance with Federal guidelines established in Public Law 94-142. Each district will be monitored as part of ongoing compliance activities and will have to document its attempts to screen the population that may be in need.

The existing problems within the education and mental health systems in providing services to the children and adolescents with emotional disturbance also is indicative of the lack of coordination of services. As many of the previous national reports have stressed, coordination of resources across child-serving agencies is essential to the improvement of services to emotionally disturbed children and adolescents. The coordination effort must, of course, be led by the Texas Department of Mental Health and Mental Retardation. The department's efforts toward system improvement began in 1987 with the appointment of a program specialist for children and adolescents. During the last legislative session the role and function of this position was expanded to include policy and program development. The establishment of the TDMHMR Operations Planning Committee for Mental Health Services to Children and Adolescents also has helped to solidify the new centralized focus. This group is composed of regional representatives responsible for recommending policy and procedure changes. As previously mentioned, they also will develop the first state plan for children and adolescent mental health.

The evidence of support for the expansion of the mental health system of care is apparent not only within TDMHMR but through legislative mandates as well. These include the following:

*Senate Bill 257 TDMHMR Enabling Legislation*

a. Provides for joint study on current methods for treatment of child abuse with the Texas Department of Human Services (TDHS).
b. Provides for evaluation and diagnostic services to emotionally disturbed children referred by TDHS.

*Appropriations Bill 40*
Appropriates funds of $3.2 million to the Texas Department of Mental Health and Mental Retardation for care and treatment, including residential placement, for mentally retarded and mentally ill school-age individuals.

*Senate Bill 298 TDHS Enabling Legislation*
Establishes the Children and Youth Services State Coordinating Committee within the Health and Human Services Coordinating Council (HHSCC) and mandates a memorandum of understanding for the development and coordination of services to multiproblem children and youth between the Texas Department of Mental Health and Mental Retardation (TDMHMR), Texas Youth Commission (TYC), Texas Juvenile Probation Commission (TJPC), Texas Education Agency (TEA), Texas Department of Health (TDH), Texas Rehabilitation Commission (TRC), and the Texas Commission for the Blind (TCB).

*Senate Concurrent Resolution 58*
Directs TDMHMR, TEA, TDHS, TDH, TCB, and TRC to develop an interagency agreement for a continuum of services to children with disabilities in TDHS conservatorship.

*Senate Concurrent Resolution 135*
Requests continued cooperation of TDMHMR, TEA, and TRC in implementing the interagency agreement to improve the coordination of services to persons with disabilities.

*Senate Bill 33 TYC*
Mandates the development of a memorandum of understanding between TDMHMR and TYC to improve the provision of services to mentally retarded and mentally ill juvenile offenders.

*Senate Bill 1 TJPC*
Creates appropriations for challenge grants to mental health centers for treatment of children in the jurisdiction of the juvenile court who are abused, neglected, mentally ill, or mentally retarded.

The vision for children and adolescent mental health services is one that includes designated funding, collaborative and coordinated services between agencies, developmentally appropriate treatment programs which are community based, family-centered services which maintain integrity and encourage parent involvement in planning, and service delivery and advocacy.

Stroul and Friedman (1986) used the term "system of care" to describe the network of service components and the philosophical tenet on which services must be based. These components consist of a continuum of

services found within mental health, education, health, recreational, and vocational services (see Appendix C).

It often is said that "problem" is just another word for opportunity. We have many chances for opportunity in the improvement of mental health care within Texas. It is time to commit, to making the vision a reality.

## Appendix A

### Priority Populations

#### Mental Health

The priority population is that group of children and adults who, according to specified criteria, are most in need of treatment and support from the TDMHMR service delivery system. The determination of need is based upon a mix of characteristics which render the mentally dysfunctional individual to be currently or potentially dangerous and/or dependent upon external community resources and therefore at risk of institutionalization.

Priority service groups I, II, III, IV, and V are eligible for the receipt of services funded with any funds received from the department or its state facilities and the required local match. The priority population service groups are listed in order of priority for use of state funds. It is not anticipated that sufficient state funding will be available to meet the needs of all persons within these service groups; therefore, clients in higher priority service groups should be given preference for programs and services. Nonpriority service group VI members are eligible to be served with center resources funded by nondepartmental sources, e.g., local nonmatch, contributions, grants.

Assignment of persons to service group categories must be performed by a qualified mental health professional.

I. *Chronically dysfunctional mental disorder, with present dangerousness and/or dependency:* A person with mental disorder of at least two years duration (or six months' duration, if a disorder of infancy, childhood, or adolescence) with present dangerousness and/or dependency.

Present dangerousness involves a condition of substantial likelihood for inflicting injury on self or others, including such recent acts as:

- ☐ combative/aggressive behaviors or convincing verbalizations or menacing overtures toward others; *or*
- ☐ convincing self-injurious verbalizations, self-injury, or actions conveying self-injurious intent.

Present dependency involves a condition of inability, because of mental disorder, to meet basic life support needs, e.g., food, shelter, medical care, without extensive support from others outside the natural support system. Criteria for dependency include:

- ☐ unemployment due to mental disorder; *or*
- ☐ education disruption in the case of children and adolescents; *or*
- ☐ strong reliance on financial entitlements; *or*
- ☐ marked social dysfunction such as failure to meet household health standards, disorderly conduct, or frequent public intoxication.

II. *Historically dysfunctional mental disorder, with present dangerousness and/or dependency:* A person with mental disorder of less than two years' duration (or less than six months' duration, if a disorder of infancy, childhood, or adolescence) with presence of dangerousness and/or dependency and:

☐ combative/aggresive behaviors or convincing verbalizations or menacing overtures toward others; *or*

☐ convincing self-injurious verbalizations, self-injury, or actions conveying self-injurious intent.

Present dependency involves a condition of inability, because of mental disorder, to meet basic life support needs, e.g., food, shelter, medical care, without extensive support from others outside the natural support system. Criteria for dependency include:

☐ unemployment due to mental disorder; *or*

☐ education disruption in the case of children and adolescents; *or*

☐ strong reliance on financial entitlements; *or*

☐ marked social dysfunction such as failure to meet household health standards, disorderly conduct, or frequent public intoxication.

III. *Primary commitment:* A person with present dangerousness and/or dependency who has a current, first-time court commitment (including emergency detention and orders of protective custody) to psychiatric services.

Present dangerousness involves a condition of substantial likelihood for inflicting injury on self or others, including such recent acts as:

☐ combative/aggressive behaviors or convincing verbalizations or menacing overtures toward others; *or*

☐ convincing self-injurious verbalizations, self-injury, or actions conveying self-injurious intent.

Present dependency involves a condition of inability, because of mental disorder, to meet basic life support needs, e.g., food, shelter, medical care, without extensive support from others outside the natural support system. Criteria for dependency include:

☐ unemployment due to mental disorder; *or*

☐ education disruption in the case of children and adolescents; *or*

☐ strong reliance on financial entitlements; *or*

☐ marked social dysfunction such as failure to meet household health standards, disorderly conduct, or frequent public intoxication.

IV. *Chronically dysfunctional mental disorder, with threat of deterioration to dangerousness and/or dependency:* A person with mental disorder of at least two years' duration (or six months' duration, if a disorder of infancy, childhood, or adolescence) who exhibits a threat of deterioration to dangerousness and/or dependency; i.e., it is probable that, without external intervention, a worsening of the condition will occur so that the person will require further intervention for acute dangerousness and/or dependency.

V. *Dysfunctional mental disorder, with threat of deterioration to dangerousness and/or dependency:* A person who exhibits a threat of deterioration to dangerousness and/or dependency; i.e., it is probable that a worsening of the condition will progress to a level requiring a primary commitment for reason of dangerousness and/or dependency, without external intervention.

Nonpriority Population Service Group

VI. *All other persons receiving mental health services.* This category includes:

a. Dysfunctional mental disorder, without threat of deterioration to dangerousness and/or dependency: A person with a history of either short- or long-term mental dysfunction, i.e., of either less than or more than two years' duration, who exhibits no evidence of deterioration to a condition to dangerousness or dependency. This person, despite mental disorder, remains capable of satisfying basic life support needs within the support system, and exhibits no overt or implicit behaviors which convey dangerousness to self or others.

b. At risk of dysfunctional mental disorder: A person with increased likelihood of dysfunctional mental disorder who remains capable of satisfying basic life support needs in the natural support system and who is not indicating deterioration toward dangerousness. Failure to receive psychiatric service may result in subsequent dysfunctional mental disorder.

c. All other persons receiving services, or screened and referred to other community resources.

## Appendix B

### Proposed Priority Population Definition

The definitions usually used to define the characteristics of chronically mentally ill adults do not apply to children and adolescents with serious mental illness. A summary definition of the priority population for children and adolescents with serious mental illness is: those individuals under 18 years of age who, because of psychosis or other emotional and/or behavioral disorders, suffer from severe disability which requires sustained treatment interventions for a year or more and which requires attention from two or more agencies. The department's proposed priority population definition is further divided into four service groups.

#### Proposed Service Group I

*Children and adolescents with a mental disorder as defined by the DSM-III-R*[1] *who present an immediate risk of harm to self or others.* This includes those who are suicidal, self-abusive, aggressive, or destructive of property in a manner which endangers others.

#### Proposed Service Group II

*Children and adolescents with a mental disorder* as defined by the DSM-III-R[1] *(which includes pervasive developmental disorders, disruptive behavior disorders, conduct, eating, anxiety, and psychoactive substance abuse disorders) with a duration or at least six months who are being or have been released from a residential psychiatric treatment facility within the past year.*

#### Proposed Service Group III

*Children and adolescents with a mental disorder* as defined by DSM-III-R with a duration of at least six months *who present the potential risk of harm to self or others* and/or because of deterioration of self-direction and judgment, learning, and capacity for social relationships are at *risk for placement in a residential psychiatric treatment facility* and are in need of services from multiple child-caring agencies.

#### Proposed Service Group IV

*Children and adolescents who have a mental disorder* as defined by the DSM-III-R with a duration of at least six months *and are substance abusers,* who present the potential risk of harm to self or others or because of deterioration of functioning in the areas of self-care, self-direction, and judgment, learning, and capacity for social relationships are *at risk for placement in a residential psychiatric or substance abuse treatment facility* and need services from multiple caring agencies.

#### Proposed Service Group V

As defined, all other children and adolescents receiving mental health services are not included in the priority population definition.

[1]*Diagnostic and Statistical Manual,* 3rd ed., rev., 1987

## Appendix C

### Values, Principles, and Components Defining the System of Care

#### Core Values for the System of Care

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

#### Guiding Principles for the System of Care

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Components of the System of Care

1. Mental Health Services
   - Prevention
   - Early identification and intervention
   - Assessment
   - Outpatient treatment
   - Home-based services
   - Day treatment
   - Emergency services
   - Therapeutic foster care
   - Therapeutic group care
   - Therapeutic camp services
   - Independent living services
   - Residential treatment services
   - Crisis residential services
   - Inpatient hospitalization
2. Social Services
   - Protective services
   - Financial assistance
   - Home aid services
   - Respite care
   - Shelter services
   - Foster care
   - Adoption
3. Educational Services
   - Assessment and planning
   - Resource rooms
   - Self-contained special education
   - Special schools
   - Home-bound instruction
   - Residential schools
   - Alternative programs
4. Health Services
   - Health education and prevention
   - Screening and assessment
   - Primary care
   - Acute care
   - Long-term care
5. Vocational Services
   - Career education
   - Vocational assessment
   - Job survival skills training
   - Vocational skills training
   - Work experiences
   - Job finding, placement, and retention services
   - Supported employment
6. Recreational Services
   - Relationships with significant others
   - After-school programs
   - Summer camps
   - Special recreational projects
7. Operational Services
   - Case management
   - Self-help and support groups
   - Advocacy
   - Transportation
   - Legal services
   - Volunteer programs

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# Families of the Mentally Ill in Texas

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## Fifteen Years in the Texas State Mental Health System

It actually has been more than 15 years since our family became intimately involved on a daily basis with the Texas Department of Mental Health and Mental Retardation (TDMHMR) facilities and services. For a number of years it was extremely difficult to consider anything beyond our immediate needs. Now that our son's mental illness has reached a somewhat less florid stage, we can take a closer look at what has happened to mental health care in Texas through the eyes of the family. In this paper we refer to our experience with mental illness. We also report a few of the experiences of many other families with whom we have been in contact in Alliance for the Mentally Ill groups or, for one of us, as a mental health professional working with families. The focus of the paper is on family contacts with the public sector mental health system, excluding the Veterans Administration, and is critical of the system in Texas. The large number of families who have told of their experiences are highly supportive of the positive changes that have taken place within the system of services, but to date families find themselves in agreement with Torrey and Wolfe (1986) in rating services in Texas very low indeed. Surveys of families have shown that families tend to be quite critical of mental health services, more critical than service providers (D.L. Johnson, in press).

We also have placed more emphasis on the activities of the Texas Alliance for the Mentally Ill (TEXAMI) than on other mental health advocacy groups such as the Mental Health Association because TEXAMI, being a more recent development in Texas, may be less well known and because it is the only organization which directs its efforts exclusively toward improving the well-being of persons with serious mental illnesses.

## Health Care for the Nation, But Not for the Mentally Ill

In an effort to make health care more responsive to the concerns of the users, legislative mandates in the 1970s for comprehensive health planning brought consumers onto health care boards and councils throughout the nation. A glance at the Texas State Health Plan (Texas Department of

Health, 1977) and every local Texas plan, however, reveals that in the case of mental illness, professionals, providers, drug companies, and lawyers were accepted as representatives of mentally ill persons and their families. Families of the mentally ill were not recognized as stakeholders in decisions which profoundly affected their lives and those of their mentally ill family members.

There were several reasons for this. One important reason was that family views were not known. Families had no voice of any sort; not through the professional literature, nor in the popular press, nor even on mental health boards. The other important reason is that professionals and providers did not believe that the family point of view could be either valid or reliable. The credibility of families was undermined by the professional literature on the etiology of mental illnesses, which is replete with examples of family blaming (e.g., Bateson, Jackson, Haley, & Weakland, 1956; Fromm-Reichman, 1948; Harbin, 1978; Lidz & Lidz, 1949). Families themselves, perhaps doubting their own experience, feeling too guilty to act, or afraid of losing the few services available to them, did not talk back (Creer & Wing, 1975).

## System Dynamics

A major aspect of families' experience of mental illness is the struggle to get help for their suffering family members. They are in contact with the health care establishment over a period of many years, usually for the remainder of their lives. Family goals are long-term, seeking genuine improvement; but families realize that the seriousness of the condition makes cures unlikely. As taxpayers and as citizens they seek effective mental health services.

Families speak of "the system," referring to state Mental Health and Mental Retardation programs and facilities. Within months of the diagnosis of serious mental illness, virtually all families have spent their lifetime insurance reserves and often a major proportion of other resources, and find themselves indigent insofar as the care of their mentally ill family member is concerned. It is only a matter of time, therefore, until virtually all seriously mentally ill persons become clients of the public system. The experience of families contrasts with the usual administrative reports which include complex organization charts and "number of patient visits" reports. Many families live with mental illness all day, every day, and see the system as it actually functions at the grass roots level over a long period of time.

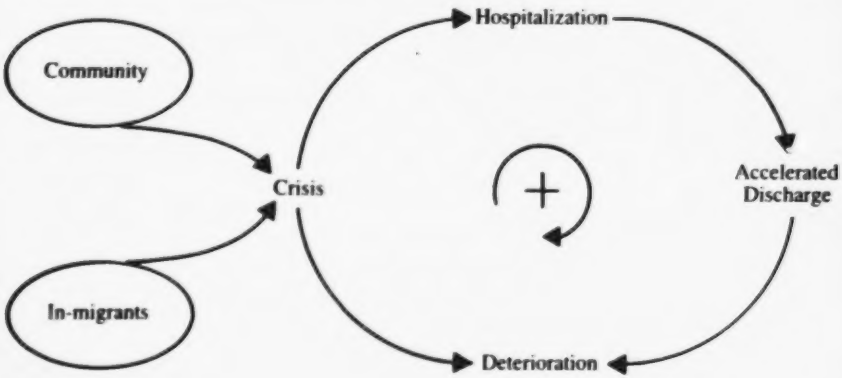
Deinstitutionalization (Mandersheid & Barrett, 1987) in Texas was accomplished without family input, and largely through accelerated

discharges from state hospitals, but the system as a whole remained concentrated on tertiary care. Medication, from the family point of view, was virtually the only, though limited, treatment, and a state hospital the only gateway into public care. This was an acute care model.

The difficulties experienced by families in managing a long-term, fully disabling condition with episodic relapses such as serious mental illness in such an acute care model, may be seen in Figure 1. Aspects of this model still may be seen in the system. As the system is experienced by families, the patient's behavior must become too burdensome for an ordinary family to manage, and meet legal definitions of violence to oneself or someone else, before crisis care may be obtained, usually in a public emergency room. From the emergency room the disturbed person is hospitalized for periods of time that range from a few hours to many months. Some patients are so severely disturbed that they stay for longer periods, and a few become continuously resident. Because the state hospital system is always overcrowded, discharge is accelerated whenever possible. This means that seriously ill persons who cannot take care of themselves are sent to their home communities. Predictably, in these situations, deterioration occurs within a matter of months, leading to another crisis and rehospitalization. This sequence of events also has been labeled, "the revolving door" (Brown, 1985). It is basic to the dynamics of the state system, but it is not the whole story.

Demographic factors also have played a role in shaping the public system. In keeping with the Sun Belt trend, the metropolitan areas of Texas have received a vast number of in-migrants in late adolescence and young

*Figure 1.* The seriously mentally disabled, if not rehabilitated, form a growing burden on a young society.



adult ages (U.S. Bureau of the Census, 1970, 1980, 1985), the very ages of onset of serious mental illness. Many mentally ill persons, attempting to survive outside of public hospitals, have migrated from the north to the streets of Texas. High rates of involuntary commitment and recidivism in Texas (C. A. Johnson, 1987) are indicators that the focus of the acute care model on crisis and violence quickly becomes a vicious circle, as lack of effective treatment fosters more crisis and possibly more violence, and the coping resources of families are pressed to the limit. The jails and prisons in Texas have become overcrowded as they serve as custodians of large numbers of mentally ill persons who are held without appropriate treatment (Monahan & Steadman, 1983; Roth, 1980).

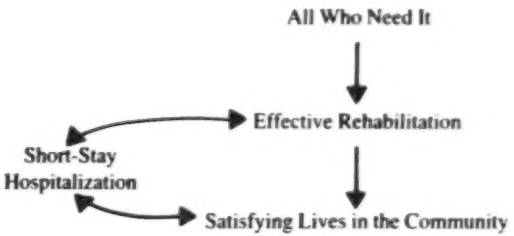
The most telling feature of the system as experienced by families is that all of the dynamics lead to a continuously increasing demand for services. New cases from the community are added to continuing cases already seen many times in the system, and to the in-migrant stream. In systems terminology this is known as a positive feedback loop, symbolized by the arrow in the center of Figure 1. State funding has not kept up with the continuously accelerating demand, and federal funding via Medicaid is severely curtailed. Thus, the system as experienced by families is chronically underfunded. Texas ranks 47th among states in per capita mental health expenditures (National Institute of Mental Health, 1985).

Families have become well informed, however, and now are demanding that modern treatment and rehabilitation technologies be made available to all mentally ill persons who need them. It is hoped that the implementation of effective programs will effect significant changes in the system dynamics described above. Families believe that it is not necessary to perpetuate the grim past. Mental health technologies with the greatest potential for modifying the traditional system include those forms of rehabilitation which have been verified empirically in the strongest of field research designs (Liberman, 1986). These include assertive case management which reaches out to recovering mentally ill persons in the community and coordinates existing community resources on their behalf (Stein and Test, 1985); Fairweather Lodges which are small, independent, self-supporting work and living groups (Fairweather, 1980); the Liberman (1987) educational programs where people who have suffered mental illnesses may learn or relearn the coping behaviors needed to live satisfying lives in the community; family management training to recognize and enhance families as a resource in the care of the mentally ill (Anderson, Reiss, & Hogarty, 1986; Falloon, Boyd, & McGill, 1984); and intensive social skills training for the most seriously disabled, continuously resident, or revolving door population (Paul & Lentz, 1977). These research-based programs are not expected to produce miracle cures, but they do provide avenues of hope for families, clients, and dedicated mental health workers.

Major difficulties lie ahead, however, in replicating and disseminating technologies which have proven successful under conditions quite different from those in Texas. Collaboration of family advocates and all sympathetic community organizations, elected representatives, decision makers, and many more will be necessary to achieve the far-reaching changes which are needed to replace the acute care model with modern rehabilitation throughout the Texas state system.

Figure 2 shows the state system relieved of the accelerating burden of untreated and badly treated seriously mentally ill persons by effective rehabilitation for all who need it. The dashed arrows in Figure 2 show that, as with many other long-term, disabling conditions, mental illness symptoms may reoccur even when medication and other routines are optimal. Yet when flare-up is appropriately managed, hospitalization is rarely needed, and then only for short lengths of stay, allowing the mentally ill person to return quickly to his or her rehabilitation program and to a satisfying life in the community.

*Figure 2.* Modern treatment of serious mental illness.




## How to Get from Here to There

Genuine changes in the Texas state system have come painfully, primarily under pressures from outside the mental health system. Major among these can be mentioned the *R.A.J.* settlement in federal district court to the suit brought by families with mentally ill persons in Texas state hospitals (*R.A.J.* Review Panel, 1987). The scrutiny and resulting decisions coming out of the *R.A.J.* suit strengthened families of the mentally ill as an independent lever for change as they were brought forward to identify themselves and express the needs of their seriously mentally ill loved ones. The Mental Health Association set up emotional support groups called Family and Individual Reliance (FAIR) groups, and included families on

task forces charged to review housing for the mentally ill in Texas communities. The family movement had reached Texas. Its potential was yet to be realized.

Decision makers up to this time usually had believed that they were allotting an optimal amount of resources to the care of the seriously mentally ill, given the constraints of political credibility and the relatively hopeless outlook for the mentally ill. Families of the mentally ill have joined other organizations to dispute this vigorously since the emergence of the state organization, TEXAMI. Significant additions to the funds available for mental health services in times of fiscal stringency would be unthinkable without TEXAMI and the Mental Health Association, but one victory after another on local, state, and national levels attests to the importance of family power in the improvement of services for the seriously mentally ill. Thanks largely to the untiring efforts of these coalitions, Texas may be the first state in the nation to turn sharply away from custodial care and implement a statewide policy of effective rehabilitation.

## Will Democracy Work?

The Texas Alliance for the Mentally Ill is composed of families of seriously mentally ill persons, recovering mentally ill persons, and caring professionals. Families include siblings, parents, spouses, adult children of the mentally ill, parents with mentally ill young children and adolescents, and other relatives.

The grass roots nature of the movement is clear as families from all walks of life and all population groups recognize a kinship forged in the most severe trauma. Families have experienced suicide attempts, running away, violence, and financial ruin. Many already have lost their mentally ill family members. Many families have mentally ill loved ones in jails and prisons. For many the disturbed person is missing, whereabouts unknown. Many have been advised by professionals to abandon their disturbed family members, but find this advice unacceptable and have chosen instead to come together and work to get the services they know they need to help their loved ones get better.

Eight years ago the Hogg Foundation for Mental Health allocated funds for a review of the working of the Mental Health Code in Texas communities. Upon the conclusion of that work $1,500 remained in the budget of an organization funded by that effort: Citizens for Human Development. A group of families of the mentally ill in Houston, who had observed the work of one of the Houston task forces, requested that the charter and the remaining funds be provided to their group. This was

approved, and the group eventually became the Citizens Alliance for the Mentally Ill, now one of seven Alliances in the Houston area, and one of some 40 local affiliate family groups throughout the state.

## Three Thousand Families Cannot Be Wrong

Families' experience of the mental health system is firsthand and therefore genuine; as such it deserves scrutiny by administrators for it may indicate avenues where the organization and delivery of mental health services can directly affect the chances that mentally ill persons will have satisfying lives in the community. Furthermore, families as taxpayers are among the first to insist that public monies should be used as effectively as possible. In the sections below a closer look at system functioning from the family point of view reveals problems regarding basic dimensions which commonly are considered in the planning and organization of health services (Reeves, Bergwall, & Woodside, 1984): (1) quality, (2) continuity, (3) availability, and (4) accessibility. A few suggestions will be made regarding cost comparisons.

### *Quality*

Quality of care generally is considered the province of professionals and is met by accreditation, licensure, and peer review. However, these mechanisms have not been well informed in the past as concerns the special needs of the seriously mentally ill population. For example, TEXAMI members brought to light the fact that an inordinate number of impaired physicians were practicing in the state mental health system. Furthermore, only 76 of 206 physicians in the state mental health system had completed a psychiatric residency training program (Texas Department of Mental Health and Mental Retardation [TDMHMR], *Management Report*, 1987). Formal rehabilitation training has not generally been recognized in recruitment efforts for professional leadership, even though quality in mental health services is almost completely dependent on the quality of the leadership.

The level of violence in any population of mentally ill persons may be related to the quality of the program and staff more than to the quality of the laboratories, the record room, or the food service. When families report violence against mentally ill patients in hospitals, the violation of expectations of shelter and care makes such incidents shocking. The fears of mentally ill persons also are increased by such incidents.

The capacity to deliver services may be determined by Joint Commission on Accreditation of Healthcare Organizations' review of facility size and staffing, but the daily function of the staff is not scrutinized. On one

occasion family observers reported that the only drinking fountain in a locked day room had been badly soiled, but during the entire four hours of observation was not cleaned. Instead the nursing staff spent that time writing notes for Joint Commission review in the nursing station. The reader should consider the dry mouth caused by neuroleptic medications when evaluating the seriousness of this incident.

The Joint Commission reviews the capacity of the facility to deliver care. Families, however, review whether the care is appropriate and whether it actually is being delivered. Discharge planning is one of the most obvious areas for scrutiny. Families continue to be excluded as members of the discharge planning team, even though 65 to 75 percent of all hospital discharges in Texas are to the patient's parental or marital home (TDMHMR, *Management Reports*, various dates). This places the mentally ill person at considerable risk and the family under extreme stress.

Some discharges without family collaboration have had tragic outcomes. One young man was released from a state hospital. His father discovered his absence by chance while phoning to speak to him. The father immediately instituted a search and found the boy's body in a drainage ditch not far from the hospital grounds. Another seriously mentally ill man, discharged from a state hospital without notice to the family, walked many miles on a cold night and appeared dishevelled and barefoot at his family's door. Later that night he attempted suicide by setting himself on fire. Yet another family intercepted their seriously mentally ill son at the bus station with a slip of paper in his pocket indicating that his appointment at a community mental health center was six months hence; it was likely, given his prior history of relapse, that he would be rehospitalized before his first appointment.

*Continuity*

Historically the public health care sector in Texas was conceived as a service only for those who truly needed it, that is persons in abject poverty. This conception is now seriously out of date, as the catastrophic dimensions of long-term mental illness are recognized. Since serious mental illness strikes most often in young adulthood and without rehabilitation usually results in total disability, most mentally ill persons have not accumulated a work history sufficient to claim Social Security; thus, they are the poorest of the poor in American society. They are twice vulnerable: once by the brain disease which has made them vulnerable to stress and again by their fragile economic status.

Families have long been worried about the lack of continuity of care in the system. They have pointed to the many aspects of the system which make discontinuity likely. It is possible here to mention only a few.

The transition from hospital to community care is known to be perilous, and many patients fail it without attentive care. A patient who needs care immediately but cannot be admitted to a public facility because no beds are available may be admitted to a private hospital at family expense. Then families will learn that the patient is not acceptable to public community care facilities which accept referrals only from public hospitals. The list of similar barriers to care could be long, but the point which families wish to make is that there must be a unified system of care to prevent discontinuity.

*Availability*

In spite of a virtual moratorium on innovative programming, a number of interesting programs can be identified in the Texas state system. When families take a closer look however, it frequently has been the case that although the program has a sign on the door suggesting that it is patterned after one of the empirically verified rehabilitation technologies, in reality it has not replicated the significant features of the technology.

For example, psychosocial clubs seem to be an excellent resource for former patients, now in the community, but clubs must screen potential members, accepting only those who have recently been hospitalized and who appear able to function in a relatively unstructured environment. This, of course, leaves out the more seriously mentally ill persons who need a more structured program, as well as those who have not been recently hospitalized, living at home or near home, but who need daytime activity. These resources therefore are not available to a large number of people. Even for those patients who would qualify, psychosocial clubs are available in only approximately 10 percent of the community mental health centers.

Case management (Intagliata, 1982) is another important, well-developed, and well-documented technology which is reported to be available in virtually every community mental health center. Yet Texas families report that some case managers are reluctant to get out of their offices into the field, preferring to instruct the client by telephone. One case manager neglected to make a home visit to her client for four months, at the end of which time he required rehospitalization. Her client lived across the street from the mental health center where she was officed.

In general effective rehabilitation programs are not available to seriously mentally ill persons in Texas.

*Accessibility*

Walk-in facilities virtually are absent from the state system. Referrals from state hospitals are the only gateway into the community mental health centers for most of the mentally ill. Because extreme deterioration is a

prerequisite for entry into the state system, recovering mentally ill persons have little chance to learn to manage their own symptoms and seek help when the illness worsens, but before it reaches a crisis. Lack of walk-in, voluntary admissions increases the emphasis on crisis care rather than rehabilitation.

Often families tolerate the escalating bizarre behavior of psychiatric crisis until they can bear the burden no longer. Then they must somehow persuade the disturbed person to go with them to the hospital. A three-hour drive from a border area to a state hospital with a severely psychotic person is sufficiently traumatic in itself, but when the family then is told that the disturbed person is not sick enough to be admitted, they must drive back to the border to await further deterioration and then try the drive once more. Families in the Rio Grande Valley report that they believe it is easier for officials to deny access to hospitalization to Hispanic families. In the federal definition of a medically underserved area, travel time of an hour usually is considered unacceptable. Yet mentally ill persons, families, and social workers from the Houston metropolitan area drive four hours to Rusk State Hospital when the Harris County Psychiatric Center is full.

The accessibility of mental health services is thus clearly restricted. When population figures are considered, access appears to be even more severely limited. The TDMHMR Six-Year Plan (1988) estimates that there are currently 2,482,043 adult Texans who have at some time in their lives experienced mental illness. Of that number approximately 1,241,387, or 50 percent, will qualify as seriously mentally ill according to the definitions published in the state strategic plan. However, only 13 percent of the seriously mentally ill are expected actually to seek services (TDMHMR, 1988). Thus, 175,036 seriously mentally ill persons are expected to seek services in 1988.

That number may be compared with the 93,655 clients who actually were served by Community Mental Health Centers in 1985 (TDMHMR, *Management Reports*, various dates). This number includes clients of all ages and diagnoses, so it is undoubtedly an overestimate of the number of seriously mentally ill persons served by the agency. It is also possible that the numbers served have increased since 1985 in some community centers, so that the two factors with opposite effects should allow us to use the 1985 number with sufficient confidence for present purposes. Of these, fully 47,607 received only screening and referral, leaving 46,048 who actually were treated in some way by the state agency. Thus, of the 175,036 seriously mentally ill persons who are expected to seek services, approximately 93,655, or 54 percent, will be served and 26 percent will get something more than screening and referral.

Many families will request services but not get them. Among these are many aging parents who are caring for their mentally ill person at home or

nearby without any help from TDMHMR. Many other families will not find the courage to request services. Those who need services but do not request them are more likely to be ethnic minorities, the severely mentally disabled, and those without families to advocate for them.

The cost of services can be understood properly only in comparison to alternatives. Three such comparisons are suggested. For example, the costs as well as the benefits of custodial care may be compared with the costs and benefits of effective rehabilitation.

In this comparison the costs and benefits of custodial care are approximately the current costs and benefits of the Texas state mental health system as partially described above. Benefits of rehabilitation include additions to the numbers of independent, self-sufficient Texas citizens. Comparison cost and benefit figures are available for isolated demonstration of each of the rehabilitation technologies, but no state has adopted all of them as a focused statewide policy. Because of the long-term nature of serious mental illness, it seems likely that a concerted effort throughout the system will be more cost-effective than isolated efforts in various parts of the state.

Another appropriate comparison is that of costs only. For example, the costs of modern treatment of serious mental illness may be compared with the costs of untreated or badly treated cases in the community. Here the escalating numbers of rehospitalizations, the court procedures, and the swelling of the populations in jails and prisons have already to some extent been experienced in Texas, so that the costs of not providing modern treatment can be estimated.

Finally the benefits of traditional custodial care may be compared to the benefits of effective rehabilitation. The benefits of a traditional system of mental health services include the advantages of working with a known service organization and a present work force, as well as the risks of change merely for the sake of change without careful consideration of unintended consequences.

Families, as knowledgeable citizens, must participate in the decisions regarding costs and in the consequences of any decision made.

## New Developments in Family/Professional Relations

Many surveys have shown that when families of the mentally ill are asked what they want the first item on their list is better care for the mentally ill family member. After that they want information about mental illnesses, access to resources, training in how to cope with the stresses of living with mental illness, and understanding and respect by the mental health professionals involved (D.L.Johnson, in press). This list is appar-

ently at odds with what professionals have expected because, first, families have been neglected for the reasons given above and, second, they have been regarded as pathological and therefore in need of therapy themselves (Harbin, 1978). Until recently, the fact that they want information and access to resources seems to have escaped the notice of most professionals (Hatfield, 1979; Spaniol, Jung, Zipple, & Fitzgerald, 1985). Furthermore, although claims for the superiority of family therapy have been made (Haley, 1987), there is no research evidence that systemic or strategic forms of family therapy are of any value, and in fact they may be harmful (Terkelsen, 1983).

Nevertheless families do need and want help from professionals, and there are signs of change in the orientation of professionals to families. The history of this change begins with the search for predictors of relapse which began in the 1950s. Most of this work found only that prior history of hospitalization was a good predictor. In England a group of investigators led by George Brown persisted and found that measures of environmental stress yielded three excellent predictors of relapse (Leff & Vaughn, 1985). Environments high on these variables had mentally ill family members who relapsed at a rate of about 40 percent per nine months, even if taking medication, whereas persons in environments low on these variables relapsed at only a 10 percent rate.

These remarkable findings led to an intervention program carried out in homes in which families were helped to lower the level of environmental stress. They found that in such settings relapse was low, while in control group settings the relapse of patients, even if taking medication and receiving supportive psychotherapy, remained at the predicted 40 percent (Leff, Kuipers, Berkowitz, Eberlein-Fries, & Sturgeon, 1982; Leff, Kuipers, Berkowitz, & Sturgeon, 1985).

The results have been replicated in controlled studies by Falloon et al. (1984) in Southern California, and by Anderson et al. (1986) in Pittsburgh. Two-year follow-ups of these programs have indicated that relapse has been delayed for most patients for substantial periods of time. In the Pittsburgh work (Hogarty et al. 1986) when family psychoeducation was combined with social skills training for the patient, there was no relapse at all in the year following the program inception. These are impressive results.

These programs seem to require a team of professionals, and that is beyond the scope of solo mental health practitioners. Here, again, there have been new developments which, although not evaluated systematically, seem to offer help that is acceptable to families. Bernheim (1982) has described what she calls "supportive family counseling," a clear and direct response to what families have said they want in order to cope with mental illness more effectively. In a similar vein, Wynne, McDaniel, and Weber

(1986) have proposed a consultative model which provides information and continuing help in developing coping skills. In all of these family training programs an essential feature is that the families are informed about and encouraged to participate in the Alliance for the Mentally Ill. This is important for the networking of information that takes place in AMI groups and no less important for the sense of efficacy that grows from being a part of successful advocacy.

In Texas, family education programs known by the authors to be under way are at St. Joseph hospital in Houston, at the VA Medical Center in Houston, and in Austin through the Travis County MHMRA. Although formal evaluation has not been done, families seem to have received these efforts well. It is important that the same kinds of information should be made available to all families of the mentally ill throughout the state.

It should perhaps be noted that although these family training methods have demonstrated effectiveness in delaying relapse, there is concern among family members that their success will be used as a rationale for dumping persons with serious mental illnesses on families. Family training does not take the place of good community programs. It also might be noted that the family training programs are effective because they have an impact upon the environments in which persons with mental illnesses live. It is quite possible, although not yet demonstrated, that the same kinds of training could yield similar results when applied in other living environments including board and care and nursing homes.

## Conclusions

Families of the mentally ill are impatient for improved services because each day of delay is another day of suffering for their mentally ill family member. Furthermore, they know that more effective services which can relieve this suffering are now possible. This paper has focused on some of the specific concerns families have about public sector services, but most of the same criticisms can be made about private sector care as well. The concern of the families in either case is that effective treatment and rehabilitation be provided their mentally ill family members. Families present a pragmatic, problem-solving point of view focused on solutions to the serious problems facing the state of Texas. Joining with recovering mentally ill persons and caring professionals, their advocacy can be predicted to influence strongly the future direction of services for the seriously mentally ill in Texas.

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## Appendixes

Appendix A: Scope Statement of the Commission on Community Care for the Mentally Ill

Appendix B: Program Planning Committee

Appendix C: Workshops and Participants

Appendix A

# Scope Statement of the Commission on Community Care of the Mentally Ill

The Commission will design and take steps to implement a comprehensive, statewide plan for the improvement of community services to the chronically mentally ill in Texas. The major thrust of the Commission will be to chart a program of action that deals with the care and treatment of mentally ill adults ranging in age from 16 to 55 years. Specialized and limited attention will be given to the mental illnesses of young children (e.g., autism and childhood psychosis), the issues surrounding the mentally ill between the ages of 10 and 14, and the long-term care problems facing the mentally ill older adult. According to the Commission, "chronicity" is defined not just as the presence of a major mental illness, but as the presence of a mental illness and factors of functioning including long-term dependency and continued disability. Severe mental illness is viewed as an incapacitating condition that may yield to some improvement but always may need some sort of constant care.

The target population is defined as those individuals (1) diagnosed with either a psychotic or severe affective illness (e.g., schizophrenia, schizoaffective, schizophreniform, bipolar, major depressive disorder, paranoia, and some severe forms of borderline personality disorder); (2) who are experiencing either an acute or chronic state of their illness; (3) who are in need of either public or private care; and (4) who may have a concomitant substance abuse problem. Excluded from this group are individuals diagnosed with phobias, psychophysiological disorders (e.g., organic disorders or Alzheimer's) and general anxiety disorders.

In view of the current modern treatment and rehabilitative technology regarding the underlying factors influencing the course and outcome of severe mental illness, there is considerable latitude to pursue actively a reconceptualization of treatment services. Public policy has mandated that the burden of the mentally ill be placed in its entirety on a few major state agencies, primarily the Texas Department of Mental Health and Mental Retardation and, to a lesser extent, the Texas Department of Corrections. These agencies are expected to effectively serve all of the needs of the severely mentally ill—including training, housing, and jobs—with very limited funds. However, it is the Commission's opinion that the professional basis of care and responsibility for persons with severe mental illness must be expanded to include other state agencies such as the Texas

Rehabilitation Commission, Texas Employment Commission, Texas Department of Health, Texas Department of Human Services, Texas Commission on Alcohol and Drug Abuse, the University of Texas Medical Schools, the Veterans Adminstration Hospitals, and indigent health care programs. Moreover, an expanded dialogue is needed around issues concerning the adjudication of cases involving the mentally ill, with special importance given to the understanding and cooperation of the county judges—taking into account the needs and concerns of the mentally ill. At the local level the allied health care providers, housing authorities, transit systems, and residential care facilities, both public and private (e.g., board and care homes, nursing homes, etc.), will be examined for their present status and potential for future care and responsibility of the mentally ill.

The scope of the Commission will be to help plan a mental health system of care that functions at both the state and local levels. This strategic plan will be aimed at shifting the responsibility of care and treatment for the mentally ill from the institution to the community. Special attention will be placed on the distinctive aspects of rural communities, regional differences throughout the state, and different ethnic groups—especially the Spanish-speaking population since it is projected that the number of Mexican-American cases of schizophrenia will increase dramatically in the next five years.

Primary and secondary responsibilities of the mental health system may be conceptualized as distinctive bands of care and assistance cross-cutting the institution and the community. These bands of care include (1) critical or essential intervention services for the illness itself; (2) rehabilitation services that provide long-term treatment and networks to assist the individual in areas such as relocation, vocation, and the management of various types of services; and (3) life-support services that provide medical care, dental care, eyeglasses, orthopedic devices, residential care, food, and transportation. The Commission will address these three levels of care in conjunction with the notion of a vertical system of care, one that ranges from living at home to quality supervised intensive care for short periods of time.

Since chronic mental illness is a recurrent disorder, early detection of the upswings of the cycle and early intervention can lessen the severity and duration of a psychotic episode. Early detection and intervention can be accomplished when personnel are trained and educated about the course and outcome of severe mental illness. Moreover, the use of advanced technology, such as a psychopharmacologist being available by telephone or video to consult with general practitioners on problems that concern patient medication, can enhance greatly the early detection of problems. The Commission will attempt to pull together existing reliable information

in these areas and make it widely available to practitioners, policymakers, and the public. It recognizes the need to devise more integrated approaches that build on and go beyond the current work of individual agencies, service models, and existing technological systems.

Appendix B

## Program Planning Committee

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Appendix C

# Workshops and Participants

## Technological and Innovative Advancements

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